DOCUMENT RESUME

ED 204 936 EC 133 504

TITLE	Childfind.
INSTITUTION	Washington Office of the State Superintendent of Public Instruction, Olympia. Div. of Special Services.
SPONS AGENCY	Bureau of Education for the Handicapped (DHEW/OE), Washington, D.C.
PUB DATE	[80]
GRANT	G007800048
NOTE	143p.
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	Age Differences: *Agency Cooperation: *Community Resources: Coordination: *Disabilities: Elementary Secondary Education: *Handicap Identification: Preschool Education: Public Relations: School Districts: *Screening Tests: State Programs: *Student Evaluation
IDENTIFIERS	*Child Find: Washington

ABSTRACT

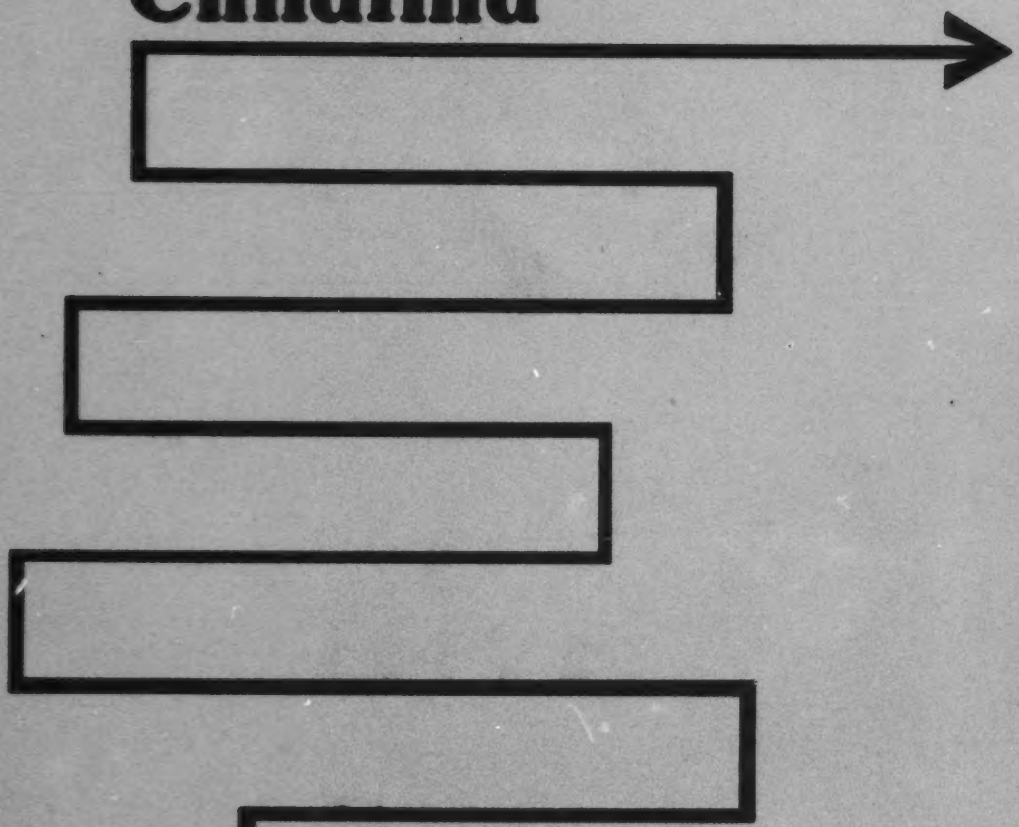
The manual suggests local approaches for childfind in Washington state. After a brief introduction, community resources are focused on in terms of surveying agencies, maintaining contact, and developing interagency agreements. A rationale is presented in Section III for using agency resources. Public awareness procedures are addressed in a fourth section. Screening rationale, procedures for different handicapping conditions, and tracking are considered in Section V. The sixth section focuses on assessment, including using the assessment data and tracking the assessment process. A final section lists state resources in childfind activities. An update on childfind data discusses several trends, including association of handicapping conditions with age. Orthopedic disability, hearing impairment, blindness, and cerebral palsy do not vary with age, while learning disabilities and communication disorders are among those conditions directly related to age. Recommendations are made for analyzing local districts, refining school referral procedures, and implementing preschool childfind. (CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED2049936

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

Childfind



Frank B. Brouillet, Superintendent
Michael G. Worden, Assistant Superintendent,
Division of Special Services
Wm. J. Hulton, Director,
Linda Espinosa, Early Childhood Coordinator

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
F. Brouillet
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC133504

Introduction

Under P. L. 94-142 and even earlier under P. L. 93-380, SEAs and LEAs were mandated to establish formal procedures for locating and identifying handicapped children who were eligible to receive special services in the public schools. These systems are commonly referred to as *Child Find Systems*. Although the responsibility for child find is jointly shared by the SEA and the LEAs, each LEA is mandated to provide evidence that they are engaged in an active program to identify, locate and evaluate all potentially handicapped individuals, ages 0-21 years.

There is a need to develop procedures that will *increase* the effectiveness of child find procedures. To meet this need, two new notions are presented with these materials: 1) systematic liaison with the location activities of other agencies (interagency involvement), and 2) procedures for locating children who are not recognized as being handicapped by their primary child care provider(s).

Interagency involvement has been a "buzz word" for some time. There are several methods presented which can lead to more effective exchanges of information and thus more complete coverage of child find activities. The second idea has to do with a change of audience in child find. A large portion of current child find activities work under the assumption that someone (usually the parent) is aware that their child has a problem but does not know what to do or who to contact. Therefore, "awareness procedures" are required in order to provide these child care providers with needed information as to who to contact for services. In reality the great majority of children who will be identified through these procedures have been identified. There needs to be a continuation of these activities for newborn children, for other children who begin to exhibit signs of potential handicapping conditions, and for families who are new to the State. However, new procedures based on the notion that the primary care provider is *not* aware of the problem need to be developed. The procedures include formal screening procedures that will allow for a more systematic search for target groups of potentially handicapped children.

Rationale

Child find is important because the data collected from such activities allow our educational system to provide the best services for children EARLY detection of children who may have learning difficulties in school allows the educational system to develop and deliver needed services to these children *before* they experience failure. Thus, child find includes activities that will focus on young children of preschool age (birth to 5 years), as well as children of school age (5 to 21 years). Early identification can:

1. Prevent learning difficulties through early intervention.
2. Prevent secondary handicapping conditions.
3. Ameliorate learning difficulties through systematic intervention.
4. Guarantee a "free and appropriate education for all children."

In addition, child find activities, birth to 21 years, are mandated by law.

Responsibility of the State Education Authority

The Division of Special Services, Office of the Superintendent of Public Instruction of the State of Washington has assumed the responsibility for statewide coordination of child find activities. The SEA will continue to provide leadership to agencies in an effort to find and serve all handicapped children. OSPI provides technical assistance, funding, training, and evaluation to agencies for child identification activities. The State monitoring supervisors continue to evaluate the scope and effectiveness of ESD and LEA child find activities.

Responsibility of the Local Education Agencies

Each local school district is responsible for implementing an active child find program. Each LEA has a designated child find coordinator. Evidence of having an active and appropriate child find program will be requested during ongoing monitoring activities. The data form for model child find programs would be one method of demonstrating that an active child find program is in place.

The implementing regulations for P. L. 94-142 (45 CFR 121.a. 220 Child Identification) state:

> *Each application must include procedures which insure that all children residing within the jurisdiction of the local educational agency who are handicapped, regardless of the severity of their handicap, and who are in need of special education and related services are identified, located, and evaluated, including a practical method of determining which children are currently receiving needed special education and related services.*
>
> *Comment: The local educational agency is responsible for insuring that all handicapped children within its jurisdiction*

are identified, located, and evaluated, including children in all public and private agencies and institutions within that jurisdiction. Collection of and use of data are subject to the confidentiality requirements in 121.a. 560 - 121.a. 576 of Subpart E.

Comment: The requirement to identify, locate and evaluate handicapped children (commonly referred to as the "child find system") was enacted on August 21, 1974, under Public Law 93-380. While each state needed time to establish and implement child find systems, the four year period between August 21, 1974, and September 1, 1978, is considered to be sufficient to insure that the system is fully operational and effective on a statewide basis.

Under the statute, the age range for the child find requirement (0-21) is greater than the mandated age range for providing free appropriate public education (FAPE). One reason for the broader age requirement under "child find" is to enable states to be aware of and plan for younger children who will require special education and related services. It also ties in with the full educational opportunity goal requirement which has the same age range as child find. Moreover, while a state is not required to provide FAPE to handicapped children below the age ranges mandated under 121.a. 300, the state may, at its discretion, extend services to those children, subject to the requirements as priorities under 121.a. 320 - 121.a. 324.

Overview of the Manual

This manual serves three major purposes: first, to stimulate thinking about child find procedures in general; second, to provide a comprehensive review of procedures and ideas that a LEA can use as a reference guide in developing a child find program; and finally, to provide actual procedures, protocols, and specific resources that LEAs may adopt --as are-- for use in child find. The manual attempts to blend theory and background with practical ideas and actual materials in such a manner that child find coordinators may be creative in their task, but also have a ready source of usable materials. Certainly, no single district would implement all the ideas presented in this manual; moreover, there may be other, more appropriate procedures currently in use in districts. This manual will be successful if it serves to stimulate a few new ideas and/or provide districts with a structure upon which to build their child find program.

SECTION II, COMMUNITY RESOURCES, presents a rationale for using community resources, and procedures for surveying community agencies and maintaining contact with those agencies. A description of the use and development of interagency agreements is also included.

SECTION III, AGENCY RESOURCES, presents a rationale for using agency resources and descriptions of the state and federal agencies that are likely to be found in each community.

These two sections, along with Section VII, Directory of Services, are attempts to foster interagency collaboration between the schools and other agencies as well as provide information about other service providers. Without systematic collaboration, schools will have difficulty remaining in compliance with the law.

SECTION IV, PUBLIC AWARENESS, presents suggested procedures for planning, implementing, and evaluating public awareness campaigns. Emphasis is placed on providing information as to: where and who to contact concerning a potentially handicapped child; how to disseminate information about available programs; and educational materials for parents and/or other individuals who typically come into contact with handicapped children.

SECTION V, SCREENING, presents a rationale for screening. Procedures for implementing a screening program for different types of handicapping conditions and for different age ranges are also included. There is a specific section on use of screening information and tracking. Finally, there is an annotated list of screening devices.

SECTION VI, ASSESSMENT, presents a rationale for assessment. Both school-based and other agency assessment services are discussed. Use of assessment data and tracking of the assessment process are also discussed.

SECTION VII, DIRECTORY OF SERVICES, is a partial listing of resources across the state.

What is Childfind?

Child find is a process of locating children who will need special services in order to experience success in school. In essence, child find procedures answer the question:

WHICH CHILDREN WILL HAVE TROUBLE LEARNING IN SCHOOL?

ANSWER: Those children who:

1. Have sensory problems (visual, auditory)
2. Have learning problems (retardation, learning disability)
3. Have motor problems (physically handicapped)
4. Have communication problems (communication disorders)
5. Have emotional problems (emotionally disturbed)
6. Have health problems (health impaired)
7. This is estimated to be about ten percent (10%) of all children.

HOW CAN WE IDENTIFY THESE CHILDREN IN ORDER TO PROVIDE THEM WITH SPECIAL EDUCATION SERVICES?

ANSWER: By identifying those children who fail to learn.

HOW CAN WE IDENTIFY THEM BEFORE THEY FAIL TO LEARN?

ANSWER: There are several different ways:

1. Many children are identified early in life and individuals in our communities know about them (i.e., physicians, public health nurses, developmental disabilities staff, etc.). We need to know our community and make sure our community knows about us. — COMMUNITY RESOURCES

2. There are formal agencies, other than the schools, which also serve children with problems. We need to be aware of these agencies and make them aware of us. — AGENCY RESOURCES

3. Sometimes parents and other adults suspect their child might have a disability, but don't know who to call or what to do. Parents, pediatricians, and other individuals in our communities need to be made aware of our services. — PUBLIC AWARENESS

4. There are many procedures available which should be used systematically to look for children who might have a problem. — SCREENING

5. Whenever we suspect that a child might have a problem, we need to assess that child in order to determine the exact nature of the problem. — ASSESSMENT

6. Our State has specific procedures which are used to determine which children are eligible for special services. — ELIGIBILITY

7. Whenever possible, we need to work cooperatively with others who serve children with handicaps. — DIRECTORY OF SERVICES

CHILD FIND IS AN INTEGRATED SYSTEM THAT SPEAKS TO ALL OF THESE ISSUES.

Childfind Monitoring Checklist

I. Number of total school age children in district. _____

II. Number of total school age children in district currently receiving special education services. _____

Percentage of school age children receiving special education services. _____

III. Estimated total number of children in district between ages birth and 5 years. _____

IV. Number of Head Start children in district who meet WAC eligibility for special services. _____

Name of Head Start contact person.

_____

V. Number of DD center children who meet WAC eligibility for special services. _____

Name of DD infant center director.

_____

VI. Actual number of children in district who meet WAC eligibility for special services:

0 - 1 years _____

1 - 2 years _____

2 - 3 years _____

3 - 4 years _____

4 - 5 years _____

Total _____

Percent of total preschool age population who meet WAC eligibility for special services. _____

VII. Name of DD Case Service worker(s) for LEA catchment area.

_____

_____

_____

VIII. Cite examples of public awareness (include samples when appropriate).

IX. Cite formal preschool screening activities.

X. Describe formal kindergarten screening procedures.

XI. Describe in-school referral procedures.

DIRECTIONS FOR COMPLETING CHILD FIND MONITORING CHECKLIST

The majority of information required to fill out the child find monitoring checklist is currently available from district records. Additional information can be found in *Child Find : A Resource Manual for Local Education Agencies.*

Question I.

The total number of school age children in your district can be obtained from the P223 form.

Question II.

The total number of school age children currently receiving special education services in your district is obtained from the P223H form.

The percentage of school age children receiving special education services in the district represents your current effort. National figures set a goal of ten percent (10%) of the total school age to be receiving special services. Your percentage should be evaluated in terms of the national figure and the uniqueness of your community.

Question III.

The estimated number of children in your district between the ages of birth and 5 years of age. This information may be difficult to locate. If need be, make an estimate based on the number of current first grade children, i. e., number of first grade children times five.

Question IV.

An estimated number of Head Start children who meet WAC eligibility for special services can be obtained by asking your local Head Start director. Some districts may choose to engage in formal screening and/or assessment of the at-risk Head Start population. The Directory of Services contains a list of all Head Start Centers in our State.

Question V.

An estimated number of DD center children who meet WAC eligibility for special services can be obtained from the local DD center director. In most cases those children who meet DD eligibility will meet the WAC eligibility for special services. The Directory of Services contains a list of all DD centers in our State.

Question VI.

The actual number of children in your district, by age groupings, who meet WAC eligibility for special services is obtained by combining the data from Questions IV and V and any other data you might have available. A conservative estimate of preschool aged handicapped children who can be reasonably identified is two percent (2%). Your efforts in locating preschool aged handicapped children should be evaluated in terms of this target figure and the uniqueness of your community.

Question VII.

The name of the DD Case Service Worker for your district may be found in the Directory of Services. This individual should be aware of all individuals who are DD eligible in your district.

Question VIII.

Cite examples of your public awareness campaign. Include samples of successful materials. See the section on Public Awareness for examples.

Question IX.

Describe your district's formal preschool screening activities. You may choose to include data on the number of children located by these activities. The section on screening may provide you with some ideas for screening.

Question X.

Describe your district's formal kindergarten screening activities. If possible, include the number of children located by these activities. The section on screening may provide you with ideas for your screening.

Question XI.

Describe your district's formal referral procedures used by teachers and other district personnel. Be sure your teachers, especially regular education teachers, are aware of these procedures.

Directory of Services

Assessment Pages 87-102

Pages 59-86 **Screening**

Public Awareness Pages 47-58

Pages 33-46 **Agency Resources**

Community Resources Pages 15-32

Pages 1-14 **Introduction**

ACKNOWLEDGEMENTS

The authors would like to acknowledge the assistance of the following individuals who participated in the development of the manual.

Public Awareness Section and Editorial Assistance	Tracy Singer
Graphic Design and Layout	Elizabeth Gong
Content Editing	Carol Davis Debora Boeck Jane Dailey
Valuable Suggestions and Insight	Clover Park School District
Typing and Secretarial Support	Linda Beaver Lorel Johnston Sami Lane Olive Wood

Special thanks to Dr. Don Whitney of ESD 121 and his staff for continuing support.

Additionally, the authors would like to thank Brian McNulty for allowing us to use *Child Find : A Handbook for Implementation*, developed by the Colorado State Education Agency as an overall model for this manual.

This manual was developed by the Office of the Superintendent of Public Instruction of the State of Washington and funded by Public Law 91-230 as amended by Public Law 94-142, Title VI, Part B, Grant #G00780048, from the Department of Health, Education and Welfare, Bureau of Education for the Handicapped. The opinions expressed herein do not necessarily reflect the position or policy of the U. S. Office of Education.

Community Resources

An effective child find system demands ongoing and systematic use of community resources. Not only is it necessary to keep other community agencies aware of local child find efforts in order to generate referrals, but ongoing liaison with other agencies will facilitate the use of the services provided through those agencies as well. This section will address three crucial elements in the use of community resources in a child find program:

A. Survey of Community Resources

B. Coordination of Community Resources

C. Interagency Agreements

Survey of Community Resourses

WHY PERFORM A SURVEY OF COMMUNITY RESOURCES?

The first step in organizing a child find system is locating all agencies and individuals in a given community which have the potential to provide services or information to support the child find system. While most agencies and individuals will be able to provide services as well as information, some will have access to information only. These contacts will generate referrals to the child find system as well as serving as a point for dissemination of awareness materials.

The Child Find Coordinator should work to develop an integrated network of services for handicapped children. Following identification, evaluation and determination of service needs, the Coordinator should know what local agencies are able to meet those needs. Awareness of other agencies is particularly important if the local education agency does not provide services to particular age groups or handicapping conditions.

Cooperation among agencies serving handicapped children is essential to a child find program. A commitment to interagency coordination can help reduce problems associated with duplications and gaps in services and confidentiality of records. A clear statement of the goals of a child find program and agreement among participating agencies will lay the foundation for effective coordination.

The purpose of a survey of community resources is twofold:

- To determine the type and level of service each agency provides to handicapped children. This will provide information for the development of a directory of community resources.
- To determine whether the agency or person will participate in the child find program, to what extent, and in what ways. This information will lead to the coordination of community resources.

HOW DO YOU PLAN A SURVEY OF COMMUNITY RESOURCES?

Many community agencies will be able to provide lists of services for handicapped children that exist in your area. Much

time will be saved if the Child Find Coordinator can locate at least one existing directory. A good place to start your search would be to check with the following agencies*:

- Local Department of Social and Health Services, Community Services Office; Case Management Services Office (Division of Developmental Disabilities)
- Local Chapter of the Washington Association for Retarded Children (WARC)
- Local Easter Seal Society
- County Developmental Disabilities Board
- Local United Way
- Local Troubleshooters office
- County Health Department

*Refer to the Directory of Services of this manual for the addresses and phone numbers of some of these agencies.

If a local directory of services is not available, the checklist of Community Resources will assist in the development of a list of community resources.

At a bare minimum, your survey should include:

- County Public Health Department
- County Office of Social Services
- Local medical personnel
- Other health facilities (hospitals, clinics, etc.)
- County Developmental Disabilities Board
- Other community boards

- Local Department of Social and Health Services (Case Management Services, Community Services Office, Regional Office, etc.)
- Head Start Agencies
- Parent Groups
- Public and private schools, including Community Colleges and Developmental Centers
- Other public and private agencies serving the handicapped
- Public service agencies, fraternal organizations
- Day care centers

Depending on the size and geographic location of your community, you may have to decide whether you will survey all of the agencies identified. You may wish to reduce your list to include only those agencies and persons that you can reasonably expect to participate in child find or provide services to handicapped children. Be certain to maintain a record of any contacts you make which you think may be helpful in the future.

HOW SHOULD THE INFORMATION BE ORGANIZED?

Information which you collect while conducting the survey should be organized in a format that is useful to the child find effort as well as to other LEA personnel who will be utilizing the information.

A sample survey format is presented at the end of this section. Regardless of how the survey information is organized, it should include the following information:

- Name of the resource, the person contacted, address, phone number
- Type of screening and/or evaluation services provided and their frequency
- Direct services provided
- Eligibility criteria (Who can receive services, under what circumstances?)
- Cost of services
- Who will they accept referrals from
- Who will they make referrals to
- Agrees to participate in the public awareness campaign
- Agrees to participate in the coordinated screening program
- Additional comments

WHAT IS THE BEST WAY TO MAKE INITIAL CONTACTS WITH COMMUNITY RESOURCES?

The size and location of your community will determine, in part, the type of initial contact to be made. In a large metropolitan area, a letter may be the best approach. Telephone or personal

contacts may be best in smaller communities. The Child Find Coordinator may wish to call a meeting of the representatives of all the identified agencies in order to discuss the goals of child find prior to requesting a commitment to participate in the program.

The type of assistance desired from many organizations and agencies will be readily evident. However, for some community groups, your request for assistance and cooperation may need to be specific. For example, it is clear that the local Head Start center could cooperate by making referrals, sharing information and accepting referrals. A number of these options may be chosen, depending on community needs. However, when contacting a Senior Citizen group, the type of participation that is requested should be specific. The Child Find Coordinator should be prepared to make suggestions such as assisting at child find screening, distributing awareness materials, or stuffing envelopes. An introductory letter followed by a personal visit is another alternative.

Initial contacts are crucial in marshalling the continued support and cooperation of other agencies. Be careful not to ignore important community groups. Keep these rules in mind:

- Use each agency as a resource to acquaint you with other persons, services, organizations, in the community.
- Remember that the agencies you contact have already been providing community services.
- Be flexible
- The options of many types and levels of participation in child find should be made available to the agencies, persons and organizations you contact.

Checklist of Community Resources

PUBLIC AGENCIES:

_____ Department of Social and Health Services*

- _____ Case Management Services Offices, Division of Developmental Disabilities*
- _____ Community Services Offices[1]
- _____ Juvenile Rehabilitation
- _____ Vocational Rehabilitation
- _____ Regional Office*
- _____ Regional Advisory Committee

_____ County Health/Social Services Department*

- _____ Maternal and Child Health
- _____ Crippled Children's Services
- _____ Developmental Disabilities Board*
- _____ Well-Child Clinic
- _____ Family Planning
- _____ Mental Health Board*
- _____ Nursing Services
- _____ Drug and Alcohol Abuse Board*

_____ State Schools for Retarded, Deaf and Blind*

_____ Educational Service District

_____ Other School Districts

*Indicates that agency is listed in the Directory of Services in this manual.

[1]Please note that the Community Services Offices contain a number of programs. It may be necessary to contact each program manager individually.

_____ Developmental Centers*

_____ Head Start*

_____ Community Colleges

_____ Community Home Health Agencies*

_____ Troubleshooters

*Indicates that agency is listed in the Directory of Services in this manual

SOCIAL AND CIVIC ORGANIZATIONS:

_____ PTA

_____ Big Brothers/Sisters, Incorporated

_____ Goodwill Industries

_____ United Way

_____ Veterans of Foreign Wars

_____ Senior Citizens' Groups

_____ Salvation Army

_____ American Legion

_____ Jaycees

_____ Knights of Columbus

_____ Masons

_____ Elks

_____ Eagles

_____ Shriners

_____ Moose

_____ Lions

_____ International Order of Odd Fellows

_____ YMCA and YWCA

_____ Boy and Girl Scouts

_____ Campfire Girls

_____ Red Cross

_____ Kiwanis

_____ Rotary

_____ Local Women's Groups

_____ Optimists

_____ Soroptimists

_____ Religious Community Centers, Services, Organizations

_____ Council for Exceptional Children

_____ Washington Association for Retarded Citizens

_____ Washington Epilepsy Association

_____ Washington Association for Children With Learning Disabilities

_____ Planned Parenthood

_____ Easter Seal Society

_____ March of Dimes

_____ United Cerebral Palsy

_____ Parent Organizations

_____ Washington Association for the Education of Young Children

_____ Medical Societies

_____ Professional Women's Associations

_____ Local and Community Hospitals

_____ College and University Special Education Departments

_____ Day Care Programs

_____ Private Preschool Programs

_____ Chamber of Commerce

_____ 4-H Clubs

_____ Washington Education Association

_____ Grange

Sample Survey of Community Resources Chart

NAME OF RESOURCE/AGENCY ADDRESS/PHONE NUMBER:	TYPE OF SCREENING OR EVALUATION PROVIDED AND COST:	DIRECT SERVICES PROVIDED AND COST:	ELIGIBILITY CRITERIA (AGE, INCOME, RESIDENCE, HANDICAPPING CONDITION)

Sample Survey of Community Resources Chart Cont.

NAME OF RESOURCE/AGENCY/ ADDRESS/PHONE NUMBER	WILL ACCEPT REFERRALS FROM	WILL MAKE REFERRALS TO	WILL PARTICIPATE IN PUBLIC AWARE-NESS CAMPAIGN. HOW?	WILL PARTICIPATE IN COORDINATED SCREENING PROGRAM. HOW?	ADDITIONAL CONFIDEN-TIALITY FORM, ETC.

Coordination of Community Resources

WHY COORDINATE COMMUNITY RESOURCES?

As was mentioned earlier, the coordination of community resources results in greater efficiency in and access to services. Given that the local education agency has the responsibility to provide special education *and* related services, it behooves school districts to identify and use the services provided by other agencies. Unfortunately, in most communities, there is no single entry point into the service delivery system which assures access to all of the services available to a handicapped child and his or her family.

Assuming that a local education agency is willing to fulfill the role of a service coordinator, both to ensure the provision of related services and to assure that all the needs of the school aged handicapped population are met, the coordination of all available resources in the community is necessary. Some communities may have already established a coordinated network of services; in these cases the Child Find Coordinator need only tap into that system. However, in many communities, there is little coordination of services. Through the development of a child find system this need can be partially met.

HOW CAN COMMUNITY RESOURCES BE COORDINATED?

Once a survey of community resources has been conducted, the information necessary to begin a coordinated child find effort is available. One way to organize this information is to transform the list into a service matrix or chart that will show at a glance what type of services and level of involvement can be expected from each provider. A sample matrix is displayed at the end of this section. In the absence of a matrix, a service directory can be developed.

From the organized information, it will be possible for the Child Find Coordinator to refer identified children to the services they need or which are indicated on the Individualized Education Program. This type of coordination of individual services places the LEA in the position of a "Direction Service" provider. More information on this concept is available from the Division of Special Services, Office of the Superintendent of Public Instruction. The information maintained in either the matrix or the directory of services should be updated periodically. This can be a tedious task, but it is important to provide continuously accurate information. Updating can be accomplished by informal phone calls or through the mail. This process also helps keep others aware of your child find efforts.

You may find it useful to work through one key person in an agency. Many times, inconsistent policies are represented by various persons within an agency. Limiting your contacts to one individual may be the way to get results. However, you may find that working with committees or groups will be most effective with other organizations.

Ongoing communication can also be maintained through the development of a local steering committee. In this way, representatives of key agencies can be included in the planning and implementation of a child find program.

In order to document your child find efforts, as well as to keep track of communication between agencies and a record of their commitments, it is a good idea to maintain a log of agency contacts. Such a record is helpful in evaluating a child find program and providing evidence that it is indeed "active and ongoing." A sample log is displayed at the end of this section.

The organization of community resources information will provide the raw materials for coordinating resources on a community-wide basis. As you begin to work closely with the total service network in your area, you may see duplications and gaps in services, conflicting procedures and policies and other barriers to effective service delivery. The following discussion on interagency agreements addresses these issues and how to improve the coordination of services.

Matrix of Community Resources (For Screening and Evaluation)

Handicapping Condition	Screening	Diagnosis & Evaluation	Medical Treatment	S.S. & Counseling Support	Physical Therapy	Speech & Language Therapy	Occupational Therapy	Educational Program
Mild to Moderate Retardation	CDC GSH (MHC) MAMC	MB (LC) CDMRC CDC MB (OPT) COHMC CSGC GSH (MHC) MAMC	COHMC SIHB	COHMC GSH (MHC) SIBH	COHMC MB (OPT)	COHMC	COHMC MB (OPT)	MB (LC)
Hearing Impaired Communication Disorders	CDC GSH (MHC) MAMC SHSC	CDMRC NH CDC SHSC COHMC UWHSC CSGC GSH (MHC) MAMC MB (LC) MB (SLC)	COHMC	COHMC GSH (MHC)	COHMC	COHMC MB (SLC)	COHMC	MB (LC)
Behavioral Disabilities	CDC MB (BSS)	CDC UWH COHMC CSGC GSH (MHC) MAMC MB (BSS) RCC	COHMC	COHMC GSH (MHC) MB (BSS)	COHMC	COHMC	COHMC	
Cerebral Palsy	CDC MAMC SHSC	CDMRC MB(OPT) CDC NH COHMC SHSC CSGC WSCPC GSH (CTU) MAMC SCCP MB (LC) UWHSC MB (SLC)	COHMC GSH (CTU)	COHMC	MB (OPT) COHMC	COHMC MB (SLC) MB (OPT)	COHMC MB (OPT)	MB (LC)

Developed by Technical Assistance Development Systems (TADS).
Information drawn from ESD 121 Assessment and Evaluation Conference Manual (1978)

Code	Definitions
CDMRC	Child Development and Mental Retardation Center
CDC	Child Development Center
COHMC	Children's Orthopedic Hospital and Medical Center
CSGC	Child Study and Guidance Clinic
GSH (CTU)	Good Samaritan Hospital (Child Therapy Unit)
GSH (MHC)	Good Samaritan Hospital (Mental Health Center)
MAMC	Madigan Army Medical Center - Pediatric Clinic
MB (LC)	Mary Bridge Child Development and Learning Center
MB (BSS)	Mary Bridge Children's Health Center (Behavioral Science Service)
MB (SLC)	Mary Bridge Children's Health Center (Speech & Language Center)
MB (OPT)	Mary Bridge Children's Hospital (Occupational & Physical Therapy)
NH	Northwest Hospital Speech & Hearing Center
RCC	Ryther Child Center
SHSC	Seattle Hearing and Speech Center, Inc.
SIHB	Seattle Indian Health Board
SCCP	Spastic Children's Clinic & Preschool
UWHSC	University of Washington Hearing & Speech Clinic
UWHPC	University of Washington Hospital, Parent-Child Learning Clinic
WSCPC	Washington State Cerebral Palsy Center

Log of Community Contacts

DATE	PERSON/AGENCY CONTACTED	PHONE, LETTER, VISIT	SUMMARY

Agency Resources

Interagency Agreements

WHAT IS THE PURPOSE OF AN INTERAGENCY AGREEMENT?

Interagency agreements define exactly how agencies will cooperate in the provision of services. They can range from an agreement to refer children between agencies and the exact form that will be used in the transfer of information, to an agreement to provide services according to similar quality standards. In *A Primer on Interagency Agreements*, Interagency Agreements, In *Interagency Collaboration on Services for Handicapped Persons*, Conference Handbook, Northwest Regional Resource Center, 1978, Robert Audette defines three hierarchical classes of interagency agreements:

Class I - Common or Baseline Standards

These are promises by different agencies to adopt common or specific criteria in the provision of services to handicapped children and their families.

Class II - Allocation of Resources

These agreements consist of promises regarding the use of agency resources in the accomplishment of mutually agreed upon objectives.

Class III - Uniform Processes, Forms and Activities

These are promises to use uniform processes, forms and activities by multiple agencies offering comparable services.

Many of the types of interagency agreements discussed above require lengthy planning and detailed analysis of complicated issues, particularly Class III agreements. In other words, this is no simple task! However, the benefits that can be reaped in terms of efficiency and improved quality are well worth the time and effort.

HOW CAN INTERAGENCY AGREEMENTS ASSIST IN A CHILD FIND PROGRAM?

First of all, interagency agreements can assist in the coordination of community resources by establishing specifically, and in writing, how agencies will work together. This type of formal agreement should assure commitment to promises made by various services providers. Secondly, if the terms of the agreement eliminate a gap or duplication, and/or facilitate information exchange or the sharing of resources, coordination can be greatly improved. A formal interagency agreement can define the responsibilities of various agencies and clarify those gray areas which result in the denial of services to many children.

In global terms, a complete network of interagency agreements can define a child find system. Service system options can be increased and available resources used more effectively.

HOW ARE INTERAGENCY AGREEMENTS DEVELOPED?

Through practical experience with the child find system, a Coordinator will be able to identify areas where a need for coordination exists. Perhaps the assessment tool utilized by a local Public Health Department is not recognized by the public schools as providing documentation of eligibility for special education. The LEA would then make a second evaluation -- an unnecessary duplication in services. Given this situation, the Child Find Coordinator might approach the Public Health Department with the problem and make a joint determination as to whether their respective regulatory requirements would allow the use of a common instrument.

It may happen that the Child Find Coordinator could use the services of a clinical nurse practitioner to perform health screening at a roundup. Again, the local Public Health Department may have a Maternal and Child Health screening program which can provide the necessary services and thereby partially fulfill their mandate. An interagency agreement could define the parameters of such an arrangement.

Another example of how a Child Find Coordinator could identify a need for an interagency agreement involves Head Start. Since Head Start has a mandate to provide enrollment opportunities for children with handicaps at a level of ten percent (10%), it would behoove the Child Find Coordinator to maintain close contact with Head Start agencies in order to identify handicapped children. The Head Start agency might need the services of a psychologist as well as a nurse to conduct screening and evaluation. A three-party agreement could be developed to include an LEA psychologist and a public health nurse funded in part through Medicaid's Early and Periodic Screening, Diagnosis and Treatment, (EPSDT), as part of the assessment team. This practice would assist the LEA in its identification efforts, the public health program in its responsibility to provide health services to low-income families, and the Head Start agency in identifying children in need of special education.

While practical experience with the child find program will assist the Coordinator in identifying areas where there is a need for an interagency agreement, a systematic approach may also be employed. Given the time and resources, a community steering committee, composed of representatives of agencies providing services for the handicapped, can be established. This is an ambitious undertaking, yet such an approach can produce tremendous effects.

The steering committee can establish community goals and find ways to meet those goals. Following the identification of goals, the baseline standards for the provision of services can be drafted (a Class I Agreement). This would provide continuity, uniform quality, and common knowledge across agencies as to how, when, where, how often, etc. services may be provided by participating agencies.

As the committee continues to function, interagency agreement needs will surface, to be dealt with by the group. Undoubtedly, barriers to effective coordination will emerge that can only be dealt with through changes at the state level. Constraints imposed by conflicting regulatory requirements frequently inhibit cooperative efforts on the local level. An organized group can raise these issues, accompanied by solutions, before their funding agents.

This section describes the agencies that will most likely be found in every community. Procedures for surveying these agencies are found in *Section II, Community Resources*. Addresses and other information regarding the agencies are found in *Section VII, Directory of Services*.

An understanding of the types of services offered by various agencies will assist the Child Find Coordinator in locating the appropriate agencies when specific services are needed. These descriptions will also assist in providing a conceptual framework for the service delivery system.

Agency Descriptions

AGENCY: COUNTY HEALTH DEPARTMENT

Each County Health Department offers a variety of health related programs and services to all residents of the county under various circumstances. Each program will have specific eligibility criteria which can vary from county to county. Close contact with the director of the County Health Department and the coordinators of the individual programs will facilitate the use of services and the sharing of information with the Child Find Program. Although most health services are directly provided by the local health department, some services are provided through contractual arrangements between the counties and private vendors and/or other agencies (e.g., hospitals, private clinics).

PROGRAMS WITHIN THE AGENCY: (not all of these programs will be present in each Public Health Department)

1 Maternal and Child Health:
Well child clinics; maternal/child nursing assessments; other services which vary by county (Does not include diagnosis, evaluation or treatment).

2 Crippled Children's Services:
Diagnosis; surgery; hospital care; occupational or physical therapy; treatment consultation; specialized care; speech therapy; hearing aids and therapy; oxygen therapy and other life support equipment under specific conditions; psychiatric, psychological and/or psychosocial evaluations under certain circumstances; special equipment such as braces and wheelchairs, but not medication or communication equipment.

3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT):
Medicaid eligible children can receive screening, diagnosis and treatment services through clinics or private vendors. Some health departments provide clinic services through the EPSDT program.

4 Family Planning:
Reproduction and birth control information; counseling and referral for crisis pregnancies, prenatal care, and abortion; sterilization, infertility and sexual problems; pregnancy determination; venereal disease screening.

5 Nursing Services:
Clinical services; child health services; immunizations; public health services to high risk mothers and infants; home visits.

AGENCY: COUNTY OFFICE OF SOCIAL SERVICES

Each county offers a variety of social service programs through contracting agencies which include mental health, drug abuse, alcoholism and developmental disabilities services. Information and referral, monitoring, planning, coordination and community education are also provided through these offices. The county office which administers social services is called by different names in the various counties. To find the addresses of these agencies, and their governing boards, refer to Mental Health Boards and Developmental Disabilities Boards in the Directory of Services in this manual. Each program has a board comprised of community representatives which assist in planning and evaluation. In some cases, a single board may be responsible for more than one program, e.g., a combined Mental Health/Drug Abuse Board.

PROGRAMS WITHIN THE AGENCY:

1 Developmental Disabilities:
Generally consists of services provided by contracting agencies. Developmental Centers are the most common type of service providers.

2 Alcoholism:
A wide variety of services provided to alcoholics and their families; to teenagers, industry and the general public.

3 Drug Abuse:
Out-patient services; residential services; and others.

4 Mental Health:
Counseling; emergency services; in-patient services; out-patient services; day treatment.

AGENCY: DEPARTMENT OF SOCIAL AND HEALTH SERVICES

The Department of Social and Health Services (DSHS) provides numerous services to eligible Washington residents. The County Health Departments and Social Service Offices receive some funds from DSHS to provide services; however, DSHS also provides direct services through Community Service Offices (CSOs). Each DSHS region (see DSHS Regional Map in Section VII) has a Regional Office which serves as the headquarters for coordinating the activities associated with the eleven (11) DSHS bureaus and divisions: Adult Corrections, Aging, Alcoholism and Substance Abuse, Children's Serices, Community and Residential Care, Developmental Disabilities, Health Services, Income Maintenance, Juvenile Rehabilitation, Mental Health, and Vocational Rehabilitation. The Regional Office staff provides liaison with other agencies, both private and governmental, which also provide social, financial or health services. In addition, the Regional Offices have the responsibility for directing the activities and programs of the Community Service Offices and their branch offices, as well as coordinating these activities with the program areas mentioned above.

DSHS REGIONAL ADVISORY COMMITTEES

The state law which created DSHS mandated that a citizen advisory committee be appointed in each service delivery region. The Regional Advisory Committees advise the Regional Director on the wide range of DSHS programs and services provided.

The functions of the committee are to: interpret community attitudes, opinions and needs to the Director; to study and analyze programs and problems; to explain programs and budget requests to the Legislature and the community; and to recommend changes in programs, policies and standards. The Advisory Committee does not administer programs or set policy. Members are selected for their interest in and ability to relate to the full scope of DSHS services.

The Committees include consumers of services; educators; legislators; professionals in various fields such as medicine, social work and business; concerned citizens and members of various minority communities; the city and county executives; the city and county councils; United Way; and the five (5) statutory boards representing Aging, Alcoholism, Drug Abuse, Developmental Disabilities, and Mental Health.

REGIONAL MANAGEMENT COMMITTEES

The Regional Management Committees were created through administrative mandate at the time of the July, 1978 reorganization of DSHS. It is the key to the Regionalization concept. The purpose of the committee is to resolve day-to-day operational problems at the local level so that programs can be more responsive to community and client needs. The Committee serves as a planning and budgeting body, as well as a mechanism to move decision-making authority to the local level for coordinating delivery of social and health services.

The Regional Management Committees are composed of the Regional Director and representatives from the eleven (11) divisions and bureaus. The committee structure promotes sharing information across program lines in order to facilitate identification of some common areas of concern. It provides a forum for solving service delivery problems.

PROGRAMS WITHIN THE AGENCY:

1 Adult Corrections:

Although Adult Corrections is responsible for penal institutions and work-training programs, the primary community activity is Adult Probation and Parole.

2 Services for the Aged:

The Area Agency of Aging is the mechanism for the coordination of private, nonprofit and government agencies into a network of services for the aged.

3 Alcoholism Services:

Alcoholism Services provide a continuum of care for the alcoholic and alcohol abuser to aid the individual in pursuing a normal life free of the problems resulting from alcohol. The comprehensive program is largely community based and utilizes individualized sequences of care.

4 Drug Abuse Services:

The drug treatment system provides a varied range of services. The overall aim of the system is to enable county residents, who are disfunctional by reason of drug abuse, to return to the community drug-free and to function at their maximum potential.

5 Children's Services:

DSHS services for children consist of direct and placement services which are administered out of the Community Services' Offices throughout each county.

The Children's Protective Service strives to identify and ameliorate incidences of child abuse, neglect and exploitation. Health Support Services, Homemaker Services and Services to Children in Their Own Homes are programs which focus on maintaining the family unit and keeping the child in her/his own home.

Placement services include Adoption, Adoption Support, and Foster Care. These services are provided when it is no longer possible or feasible for a child to remain with her/his own parent(s). Day Care offers care, protection and guidance to children during the day, while parents are working or participating in a training program.

6 Community and Residential Care Services:

Services to disabled adult clients living at home or in residential care facilities in the community are centralized and coordinated through the Bureau of Community and Residential Care. Placements of clients in long-term care facilities are coordinated with the delivery of alternative services to help avoid unnecessary institutionalization or, if placement is needed, to place clients in the least restrictive environment.

Alternatives to long-term residential placements include in-home services, home health services, adult family homes, congregate care facilities, adult day care and adult protection services.

7 Developmental Disabilities Services:

The Divison of Developmental Disabilities provides a broad range of rehabilitative resources in the community, through the Case Services Regional Offices.

Using a multidisciplinary approach, Case Services staff provide or coordinate eligibility determination; individual program planning; placement in a wide variety of residences such as group homes, state

institutions, family homes, boarding homes, and private apartments; and placement in community training programs for developmentally disabled infants, children, and adults. Case Services also offers, through its Home Aid Program, supportive services such as respite care and specialized therapies designed to help maintain the developmentally disabled person in the community.

8 **Health Services Division:**

The problems addressed by the public health program fall into three general categories: (1) protecting the health status of the population; (2) organizing the health delivery system; and (3) providing medical services to eligible persons.

The Health Services Division (HSD) has responsibility for administration of a wide range of public health programs. They include the traditional public health concerns, such as environmental health and communicable disease control, as well as personal health services and health resources development. The HSD also distributes federal funds to local agencies; sets operational standards for programs; provides technical assistance in disease identification and program development; maintains a state laboratory; collects and reports health data; and licenses and regulates health care facilities. The HSD provides for medical care for the needy through the State-Federal Medicaid Program. Other medical assistance programs include Crippled Children's Services and payment for renal disease treatment.

Public health services are provided: (1) directly to HSD; (2) indirectly through funding and support services to the twenty-eight (28) local health departments/districts which, in turn, provide services to individuals in their communities; and (3) by contract with other community nonprofit agencies. Most public health services provided directly to individuals are delivered by the local health department.

9 Income Maintenance Services:

Income maintenance services are provided through the Community Service Offices and include:

- Financial assistance through monetary grants for families and single persons
- Medical coverage for a wide spectrum of medical and dental needs, including nursing home care
- Food stamps to supplement persons with low income
- Child care for low-income working parents
- Work Incentive Program (WIN)
- Employment and Training Support Services

10 Juvenile Rehabilitation Programs:

The responsibility for the delivery of ongoing community corrections programs to young people released from state juvenile institutions lies with the Division of Juvenile Rehabilitation staff in each region.

Juvenile Rehabilitation programs include a variety of diversion programs, probation subsidy and community corrections programs funded through special grants to local units of government.

Services available for youth returning to the community from institutions include one-to-one, family and group counseling, recruitment and placement in foster and group homes, volunteer services, and education learning centers. Their services are aimed at the successful reintegration of youths into their communities upon completion of their institutional sentences. The key to planning for youth lies in the Pre-Parole Planning Review which occurs prior to release and has as its goal the development of a specific plan and support system of people to help guide the youth through the reentry process.

11 Vocational Rehabilitation Services:

The Division of Vocational Rehabilitation of the Department of Social and Health Services provides services toward restoring physically and emotionally handicapped individuals to vocational and economic usefulness.

There are two criteria by which eligibility for vocational rehabilitation services is determined:

- Evidence that a physical or mental disability is present and that this presents a substantial handicap to employment; and
- A reasonable expectation that such services will benefit the individual in terms of employability.

In the event either criterion is absent, the individual cannot be certified as eligible for services and the Division will attempt to refer the person to other resources or agencies that can most effectively offer assistance.

In addition to diagnostic counseling and guidance services, the Division offers the following services based upon the individual's needs and resources:

- Vocational guidance and counseling
- Physical restoration and training, including personal and vocational adjustment
- Books and training materials, maintenance and transportation payments, and placement follow-up services
- Tools, equipment, initial stocks and supplies and such other services as are necessary to assist the individual to become capable of engaging in a gainful occupation.

AGENCY: HEAD START

In addition to providing educational programs to disadvantaged preschool children, Head Start agencies are mandated to reserve at least ten percent (10%) of their enrollment opportunities for children with handicaps. Head Start agencies provide comprehensive developmental services to preschool children. The Head Start Performance Standards require local programs to develop an educational plan that provides procedures for ongoing observation, recording and evaluation of each child's growth and development for the purpose of planning activities suitable to individual needs. The Performance Standards also require that classroom activities and materials reflect the cultural background of the children.

AGENCY: SOCIAL SECURITY ADMINISTRATION, SUPPLEMENTAL SECURITY INCOME (SSI)

SSI is a federal program which provides payments to individuals who are either aged, blind or disabled and who have limited income and resources.

Children, at any age, may be eligible for SSI benefits. The eligibility standards for children are based on whether a comparable condition would prevent an adult from engaging in gainful work. Application for benefits is made with the Social Security Administration.

Public Awareness

Introduction

Public awareness is such an essential element of child find that your project's success may depend on it. Public awareness will help you reach the very people who need to know about child find -- parents, family friends, physicians, local agencies. A public awareness campaign will bring many more children to your screening sessions. Ongoing public awareness will result in continued community cooperation in identifying, locating, and testing children who may need special services. Public awareness will also recruit many volunteers for your district's activities, while strengthening your ties with local agencies and organizations.

There are three essential parts to a successful awareness project:

PLANNING

IMPLEMENTATION

EVALUATION

Planning an Awareness Campaign

When you plan an awareness project carefully, the actual implementation can proceed smoothly and efficiently with little direction necessary. Without advance planning, your project may attract few children.

The first step in planning is to identify what kinds of awareness activities have been tried in the past, and how effective each one was. Then, identify new resources that you can add to a permanent resources list. What kinds of resources might be helpful in an awareness campaign? Some major types are MEDIA and AGENCY resources.

MEDIA RESOURCES

- television stations
- radio stations
- community newspapers
- shopping guides or flyers
- publications or newsletters
- local company or business publications
- school publications (elementary, secondary, and college)
- publications of other agencies, especially those working with the handicapped
- welcome wagon kits

AGENCY RESOURCES

- agencies serving the handicapped
- hospitals, especially obstetrics and pediatrics departments
- social service organizations
- major employers, including banks and utility companies
- ethnic organizations
- fraternal groups
- local stores
- schools
- parent groups such as PTA
- military bases
- service groups

Once you have located media and agency resources, make contact with each. You will want to give them clear information about child find and their potential role in helping to fulfill its important mission. A section later on in this chapter will discuss types of publicity. Here are some general rules to follow in dealing with local resources:

- obtain the name, address, and telephone number of the media or agency person who handles publicity or public service activities
- write or call directly to that person and set up an appointment to meet
- at the meeting, be prepared to give the person concise and clear written information about child find and to discuss their group's role in creating public awareness
- back up your written information with well-prepared answers to all potential questions
- always call or write to thank people for their assistance
- keeping in touch with resources will help ensure continued assistance and publicity

VOLUNTEERS

There is a lot of legwork that goes into a successful awareness project. It takes time to stuff mailboxes, or make telephone calls. Volunteers can perform these and other tasks quite well and word-of-mouth is a powerful form of communication. Use volunteers to:

VOLUNTEER RESOURCES

- distribute material
- stuff envelopes
- speak to local club meetings, especially ones to which they belong
- make telephone calls or door-to-door contacts
- set up screening appointments
- answer questions by the public
- assist in counseling parents of children with special needs

Volunteers may be drawn from service and fraternal organizations, social clubs, businesses, student groups, parent associations, and teacher groups. Contact these groups, explain your purpose and needs, and request their assistance as volunteer workers.

Remember to thank volunteers and give them the recognition they deserve.

TYPES OF PUBLICITY

The single most important piece of information you can write is a fact sheet. Fact sheets answer questions such as:

FACT SHEET

WHAT?	(define child find)
WHEN?	(specific screening date or ongoing activity)
WHERE?	(name, address, telephone number of place where screening or other event will be held)
WHY?	(rationale for screening, early intervention)
WHO?	(children 0 - 21 years)
HOW?	(contact person's name, address, telephone number)

It is important that all of your publicity convey at least the same basic information. A fact sheet can answer clearly the questions most often asked. One basic fact sheet should serve for most purposes in your awareness campaign planning. If necessary, the information can be expanded for special fact sheets geared to specific audiences, such as physicians, or the media. It is important that all publicity present a unified message about child find so there is no doubt in the public mind about what child find is and what it is trying to do.

Logo or Slogan

A clear logo or slogan will be remembered longer than written information because it helps set the idea of child find in people's minds. Make up business cards which include the logo or slogan along with the name, address, and telephone number of the Coordinator. You might include the logo on all publicity, on bumper stickers, telephone stickers, and on posters. A small message that periodically appears in local publications might feature the logo or slogan to keep child find before the public.

Flyers

Flyers can be stuffed into grocery sacks or placed on car windshields in parking lots. They can be added to bill statements from banks and utility companies, or posted in the windows of businesses. They can be stuffed into mailboxes in residential areas. Older children can carry them home from school. Remember these points in making up flyers:

- use bright, eye-catching colored paper.
- keep the message clear (you might draft a flyer, then ask several people not connected with child find to read it. If they have questions about the content, revise).
- keep the overall look of the flyer uncluttered. Let the reader's eye go to the most important information.
- print enough for all uses. This means making an informed estimate about where the flyers will be distributed and how many people will receive them.
- again, be sure you have the same basic information on a flyer as in the fact sheet. Include your logo or slogan on the flyer, too.

Brochures

Brochures can be handed out at meetings of local civic clubs or placed in hospital and doctor offices. Brochures can offer important information that a flyer cannot. You may want to design a brochure which lists major developmental milestones in young children, or the warning signs of a possible developmental delay. Somewhere on the brochure, make sure you include information about where to go for more information or for child find assistance.

The overall design of the brochure, like the flyer, should be uncluttered and attractive. Try to use some other color paper than white. Print more than enough if you include valuable information of interest to professionals and parents, as you may receive additional requests. If you have a logo, put it on the cover.

Newspapers, Television, and Radio

Radio and television stations may ask for 10-, 20-, or 30-second spots that can be broadcast as time allows. Newspapers may be willing to run a feature story on child find as well as small, periodic announcements. Remember these tips when working with the media:

- find out how far in advance the copy is required (often 1 - 2 weeks before the announcement is broadcast).
- determine what audience you want to reach (generally all groups) and use the media that caters to that group. It is best to publicize in all newspapers and television and radio stations in the community.
- plan for announcements of screening sessions *no more than five (5) days in advance* of the screening, otherwise people may forget.
- send clean, typewritten, double-spaced copy of the article or news release, with the name, address, and telephone of the child find person to be reached for more information.

- *always* write a note or make a thank-you telephone call to the media for their cooperation. This is a good way to maintain support and establish rapport.

- offer to send the media additional information about the results of a media campaign. For instance, you might send them information on the number of children seen at a screening, or suggest a human interest story about a particular child or family.

- since child find should be an ongoing event, the awareness campaign should also be continuous. Check back with the media periodically to request continuation of announcements or other publicity.

Public Speaking

Word-of-mouth is one of the most effective means of wide-range communication. A well-informed speaker can convey more information more meaningfully in 20 minutes than a ream of flyers. The Coordinator, local personalities, and well-informed volunteers can all be effective speakers before civic clubs, media press conferences, teacher and parent groups, and businesses and other organizations.

Some helpful facts to remember about public speaking:

- have a well-prepared 15 - 20 minute presentation that is right for the audience.

- practice the speech and be prepared to answer questions that the group might ask.

- begin and end the speech with strong, positive statements.

- prepare visual aids beforehand. Use key words or phrases and avoid cluttered visuals.

- have handouts ready for the audience to take.

- check out the room beforehand and test audio and other equipment.

- write a thank-you to the person or group who arranged for you to speak.

TIMELINES

Timing is a key word in any campaign. Announcing a screening a month in advance gives people time to forget all about it. On the other hand, 24 hours' notice does not give parents time to plan to bring their children. Most newspapers and radio and television stations require 1 - 2 weeks advance notification for any public service announcement; business or club newsletters have their own deadlines for copy. And volunteers need enough advance warning to arrange their schedules to be there when they are needed. You must be aware of all of the different deadlines and schedules as you plan an awareness campaign.

A good way to keep track of all deadlines is to maintain a large chart which lists all public awareness planning activities and the timelines connected with each. Then, all child find staff can be aware of what still needs to be done, and by what date.

Remember, your organizational skills will reflect on the way in which people perceive the child find effort, as well as ensuring a successful campaign.

Implementation of the Campaign

If you have planned carefully and set timelines, your awareness campaign should proceed smoothly. Your timeline should become more valuable as you begin implementing an awareness campaign because it will be your best method for keeping track of what is happening and what should be happening.

SUSTAINED AWARENESS

Because child find is an ongoing activity, it is important to continue your awareness campaign even after a screening. In this way, the public remains aware of the fact that such services continue to be available to parents, professionals, and children. Some ongoing activities might include:

- public service announcements on television and radio
- newspaper or newsletter articles. Even a small blurb, run daily or once a week will remind the public. Stories about local children who have benefited from child find are sometimes welcomed by local newspapers.
- bumper stickers or other public, permanent displays of a logo or slogan
- periodic distribution of flyers, brochures, and posters

The key to sustained public awareness is periodic presentation of the same consistent, unified message. People will retain this idea if all continuing awareness campaigns concentrate on presenting the same basic message.

Evaluating Public Awareness Activities

You have just completed the planning and implementation of a fairly successful first awareness campaign. The advertised screening drew a fair number of children and your new contacts seemed helpful. Now is the time to take a deep breath and look more objectively at the campaign. What worked? What had to be modified? What areas of planning didn't produce the expected results? How could each of the planning activities be improved next time? Careful evaluation -- by yourself and by others -- will help you improve future child find awareness campaigns.

RECORD KEEPING

Keep records on every aspect of the campaign, including:

- type of resource
- contact person
  - what they were asked to do
  - what they actually did
- dates, times of importance
- copies of all correspondence
- copies of products (news articles, flyers, brochures, photos, etc.)
- comments by child find staff and others about the effectiveness of the activity

Remember to keep a list of the names, addresses, and telephone numbers of all volunteers and cooperating agencies. Follow up on contacts to thank them for their assistance. Careful record-keeping means that any one connected with child find can find the information they need, especially when the Coordinator is not available.

Write a report about the awareness campaign. It can be brief, but should include enough information so that a new Coordinator or other staff person can begin working on the next campaign without repeating steps and wasting time. Be sure to include recommendations for improving the system.

TYPES OF EVALUATION

Some types of evaluation that you may want to consider include:

- questionnaires for parents to explain how they heard about child find
- questionnaires that doctors and other health professionals can fill out regarding their information source
- questionnaires for public service agencies to complete about how they learned about child find
- numbers of children seen during advertised screenings
- numbers of volunteers working with child find (don't forget to ask for their evaluations and recommendations, too)
- number of resources contacted and number that actually helped the campaign

Screening

What is Screening

Screening is a concept that must be viewed as a process rather than as any single given event. Screening is the process of identifying potentially handicapped children. Asking people if they know of any handicapped children is as valid a screening activity as administering the Denver Developmental Screening Test to a child. Both activities have as their goal the identification of a child who *might* be handicapped.

There are several crucial assumptions regarding screening activities that must be understood:

1. Screening is only done for conditions that can be diagnosed and treated.
2. Screening must be quick; at least quicker than a complete assessment.
3. Screening must be inexpensive; at least less expensive than assessment.
4. Screening must be harmless, both physically and psychologically.
5. Screening must be cost efficient; a minimum of individuals should be identified as having a disability who, after further assessment, do not have a disability (false positive).
6. Screening must be effective; a minimum of individuals should be identified as *not* having a disability who in reality do have the disability (false negative).
7. Individuals who are identified through screening activities must be referred for indepth assessment.
8. Individuals who are determined by assessment procedures to have a specific disability must be referred for placement.
9. Screening should be designed to identify specific disabilities rather than general disability.
10. Screening is *not* one event.

There are at least two general notions that should guide screening activities. First, someone, usually the child's parent, often is concerned about their child but does not know who to contact for help. Given this assumption, primary screening activities should consist of providing these individuals with information on where to turn to for help. The great majority of children who fall into this category are already identified. Such screening efforts need to be made more efficient and need to be continued for those children who continue to develop problems as well as for individuals new to the community.

The second notion is that there are a number of children with mild disabilities who are *not* recognized as having a disability by adults in their environment. As the child's disability becomes more acute, the parents (or teacher) will probably recognize the disability and seek assistance. However, there are a considerable number of children with mild disabilities who are viewed as problem-free. There are three possible options for finding these children.

1. We can try to educate parents, teachers, and other primary child care providers about what to look for that might indicate a potential disability in their child and who to contact if they suspect a disability.

2. Someone who "knows" what to look for can interact with these children. This "knowledgeable person" would then refer suspect children for formal screening.

3. We can conduct massive screening. This can be done with "captive audiences", such as infants in newborn nurseries, day care centers, Head Start Centers, or public school classrooms. Or, we can try to collect children together in one location (commonly referred to as a "roundup") and then conduct screening.

These general procedures are the most common methods used to locate potentially handicapped children. For any given school district, some procedures may be more appropriate than others. The final test, however, is determined by the number and percentage of handicapped children the district is serving.

The following portion of this section is a more indepth description of the above concepts. Remember, one district will probably never use *all* of the ideas presented here. Rather, districts will choose which of the procedures are most effective for them based on their needs and resources.

Special Note of Caution

Whenever formal tests are administered to an individual child, the parents of the child MUST be informed of the proposed procedures and they MUST give their *written* permission for their child to be tested. This concept of informed consent has two very important aspects. First, parents have the right to be fully informed as to what is happening with their child. This is both an ethical and a *legal* right. Second, parental involvement in the education of their child is highly desired. The best way to ensure positive parental involvement is to be open with them in all instances. Regardless of intent, the law says *Parents must be informed and must give their consent!*

For Those Who Are Aware

An entire section in this manual is devoted to awareness activities. This section will briefly cover three specific awareness issues which are pertinent to screening: 1) awareness of referral procedures; 2) awareness of programs; and 3) awareness as an educational issue.

REFERRAL PROCEDURES

A continuing issue for parents and professionals is that of where to go for help when a disability is suspected. One of the factors that discourages individuals from making referrals is the old "runaround." After several unsuccessful attempts to locate the right service agency, the parents often lose hope and interest. Therefore, it is extremely important to have clear referral procedures. The person who provides *initial access* to the service system for any given client should be the person who takes charge of the referral. *Every time we refer a client on to others, we increase the likelihood of stopping the process.*

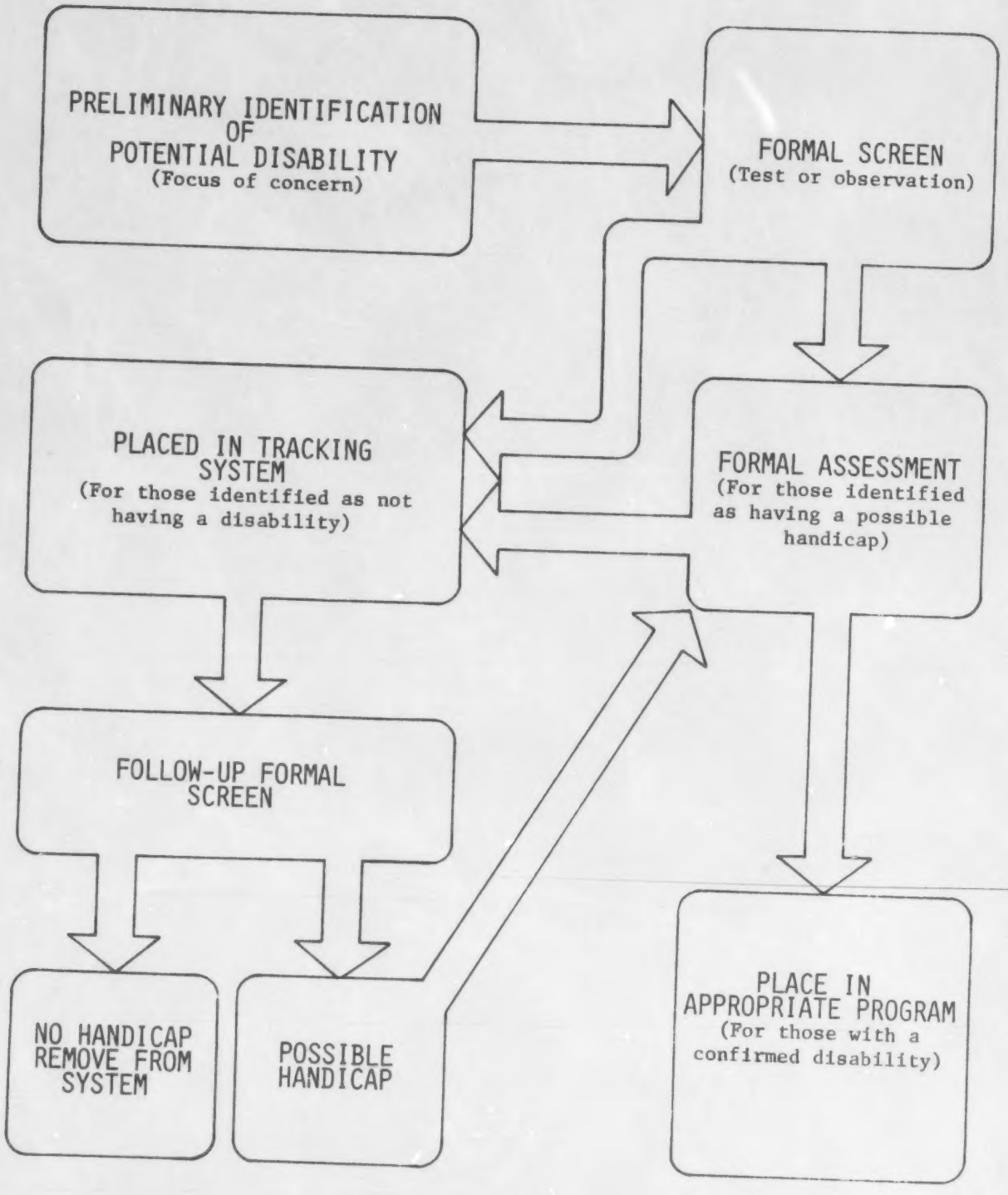
PRESCHOOL REFERRALS

Preschool referrals are a special case. A parent or primary health care provider is most likely to refer a preschool age child. Each LEA should publicize the telephone number of one individual who will handle incoming referrals as part of the basic public awareness materials. This person should retain primary responsibility for each referral until final resolution. One of the problems with this type of system is the need to have predetermined procedures for conducting formal screening, formal assessment, and appropriate placement. If a physician, for example, calls in with a referral and there is a problem in arranging for screening assessment, or placement, there is an increased probability that the physician will NOT refer another child. *IF YOU DECIDE TO USE A CALL-IN NUMBER - Be sure you have established procedures for handling all referrals.*

IN-SCHOOL REFERRALS

In-school referrals present a different type of issue. All school staff should be aware of established referral procedures. These procedures may include formal screening (e.g., kindergarten screening) as well as informal screening (e.g., building meetings). It is very important to inform all staff of the established procedures; indeed, many teachers do not know how to make a referral.

Flow Chart of Referral Procedures


PRELIMINARY IDENTIFICATION OF POTENTIAL DISABILITY
(Focus of concern)
FORMAL SCREEN
(Test or observation)
PLACED IN TRACKING SYSTEM
(For those identified as not having a disability)
FORMAL ASSESSMENT
(For those identified as having a possible handicap)
FOLLOW-UP FORMAL SCREEN
NO HANDICAP REMOVE FROM SYSTEM
POSSIBLE HANDICAP
PLACE IN APPROPRIATE PROGRAM
(For those with a confirmed disability)

For Those Who Are Not Aware

Procedures developed to find children currently unsuspected of having a disability must be developed with specific types of handicapping conditions in mind. These procedures need to be carefully fit into the overall district plan.

EDUCATION

Many activities can be developed to educate individuals in the community. This can take the form of educating parents about normal child development. Parents would then be able to determine if their child were developing at an expected rate. The next step is to provide parents with a referral procedure that would lead them into the system already described.

A second type of education program might be aimed at primary health care professionals regarding the availability of existing programs. Many physicians may recognize a child with a potential problem, but are unaware of existing programs and the effectiveness of these programs. The physicians must know more than the simple fact that the program exists; they must have confidence in the program. Different methods have been used in the past, the most successful of which have included personal contact with individual physicians or a presentation by a physician advocate to the local Pediatric Academy. Physicians generally want to make referrals but they must *know* that the program they refer to is appropriate. Meet a physician, sell him on your program, encourage him to tell others, and referrals will come.

Many communities have other individuals who frequently interact with parents and their children and who are in the position to make referrals. For example, ministers, priests, and rabbis; local Welcome Wagon personnel; Head Start staff; Day Care staff and Community College Co-op instructors are all potential referral sources. You know your community -- who deals with families? These people should be made aware of the types of children you serve and who to call if they suspect a child has a problem.

FORMAL SCREENING

There are a number of instances when formal screening is appropriate; 1) when a referral has been made; 2) when there is a "captive audience"; and 3) when a roundup is conducted. In all these cases screening should be specific. An annotated list of specific screening devices can be found at the end of this section.

REFERRALS

Whenever a child is referred for a suspected handicap, either the original agency contacted or the school district (if not the same) should handle the case promptly so that the child receives formal screening and, if necessary, indepth assessment. The addresses of local resources that may conduct screening or assessment are found in the Directory of Services.

CAPTIVE AUDIENCES

Captive audiences provide excellent opportunities for formal screening. Entire day care centers, preschools, Head Start centers and classes of school age children can be quickly and effectively screened. This is especially true for sensory screening and group test screening. A good point to remember when dealing with captive audiences is that systematic observation can be an appropriate screening procedure.

ROUNDUPS

Roundups are best devised for particular types of disabilities and usually are developed to serve a specific geographic location. Since this very well might be the first formal group experience for the children, the screening should be pleasant. Planning is crucial: How many children can be handled? Is the screening location distraction-free? What will the parents do while the child is being tested? How will the results be handled? Of special significance are the time and location -- both should be convenient for the parents of the target group. One can schedule screening roundups in school, church, shopping or community centers. With this type of screening, complete and appropriately timed publicity campaigns are critical.

The process of screening involves locating children, observing their behavior using some type of systematic procedure (e.g., Snellen Eye Chart), interpreting the information gained from screening, referring those judged as at risk for indepth assessment, and tracking the identified children through the assessment process and into an intervention program or back into their original setting. This section will focus on the interpretation of screening information.

Although each specific screening procedure will have unique instructions about how to handle the data, there are several general concepts that should be discussed. This section will focus on the issues of false positive/false negative findings, labeling, frequency of screening, and tracking (placement and reevaluation).

FALSE POSITIVE/FALSE NEGATIVE AND COST EFFICIENCY

The primary task of screening is to sort out those children who have problems from those children who do not have problems. Whatever procedure is used will result in some children being misidentified. Some children may seem to have a problem but in reality they do not. These are false positive cases. Other children appear not to have a problem but in reality they do. These are *false negatives*. What are the consequences of these errors in our screening procedure? Obviously, the ideal screening procedure would have no *false positives* or false negatives. This never is the case in real life. Therefore, each time a screening procedure is developed, some thought must be given to the issues of false positive/false negative findings.

Large numbers of false positive findings are expensive in terms of overloading the assessment system. Each child identified as potentially having a problem must be assessed. This takes time and costs money. False negative findings means passing over a child that has a problem. This results in a child not receiving needed services. S/he will undoubtedly turn up at a later date

but by that time valuable intervention time has been lost and the child has suffered. Neither situation is desirable: in one way, we lose money, in the other we lose intervention time. There are no easy answers to this dilemma; however, there are several considerations that can be used to decide on which side you choose to err.

First, what is the cost of the assessment procedure, both in terms of time and money? If the assessment is relatively inexpensive and quick, or if available assessment procedures can tolerate additional children at minimal extra cost, you might choose to increase the likelihood of more false positives in order to reach more children. This is done by loosening the standards by which the children are determined at risk. *Remember,* the consequences of this decision are that you will have a major increase in the number of children who will require a formal assessment, of which a number will *not* have a problem. On the other hand, if the assessment procedure is costly or time-consuming, you might choose to increase the criteria for referral. The result will be a decrease in the number of false positives but an increase in the number of children who need help but who are overlooked by the screening procedure.

Other considerations include the results of overlooking a child, the results of misidentifying a child as at risk, and the frequency of screening activities. If you miss a child with a disability (false negative) and the result is that the child suffers irreversable damage (e.g., permanent hearing loss as the result of infection), the screening procedure should be changed to tolerate a high number of false positives in order to decrease the chance of missing a child with the disability. If the consequences of not beginning treatment are less drastic (e.g., an articulation problem), the screening procedure might tolerate an increase of "misses" in order to cut down on the cost of assessments. Sometimes, labeling a child as at risk for a handicap might cause negative expectations and harm the child. This can be controlled by *NOT labeling any child as a result of screening.* However, if this is a danger, you would want to limit the number of false positives. Finally, if screening activities are scheduled to occur frequently, you might be less concerned with false negatives, assuming that these children would be picked up in subsequent screenings.

Screening procedures should result in as few false positive and false negative indications as possible. Child find will not be an effective procedure if a large number of children are misidentified. However, you can choose on which side to err by analyzing the consequences of each type of error.

Labeling Children as a Result of Screening

Children should NOT be labeled as a result of screening.

Children should not be labeled as a result of screening.

CHILDREN SHOULD NOT BE LABELED AS A RESULT OF SCREENING.

Frequency of Screening

The frequency of screening procedures depends on several issues: cost, effectiveness of the screening procedure, number of new children that enter the system, and the consequences of overlooking a child. Some screening is typically performed every school year (hearing, vision), other screenings occur at a given age (PKU at birth, cognitive skills at entrance to kindergarten, etc.). Other screening efforts are ongoing (in-school observation for learning problems), and still others are scheduled on demand (roundups, referrals, etc.). Every school district should have a comprehensive screening program that includes all of these types of screening procedures. The following list indicates the three major types of screening programs and activities under each:

Comprehensive Screening Program

ONGOING	● Awareness materials in community ● Formal interaction with primary care physicians ● Formal in-school referral system for suspect students (building meetings) ● Formal interaction with Head Start and DD centers ● Formal interaction with local day care and preschools ● Formal interaction with private schools ● Formal interaction with human service agencies ● Formal procedures for processing and tracking all referrals
ON DEMAND	● Referrals from parents ● Referrals from other agencies ● Referrals from physicians
REGULARLY SCHEDULED	● Hearing and vision screening in public schools ● Screening at kindergarten registration ● Formal screening throughout kindergarten and first grade ● Roundups (yearly) of prekindergarten age children

Tracking

There are three categories that the screened children may fall into. First, tests normal -- no need for further tracking; second, questionable -- the results of screening do not warrant a district referral to assessment, but there is some concern about the child's performance; third, at risk -- in need of referral for further, indepth assessment.

The first category is the easiest to handle. A simple report, either verbal or in writing to the parents, should suffice. Note, however, that this report should be written in language the parents can understand and should not overstate the case. The information passed on to the parent should include:

1	A brief explanation of the purpose of the specific screening
2	A summary of the child's overall performance
3	Recommendations for further testing, if any

The second category is the most difficult to handle. The screening personnel must make a decision about what they recommend: wait a period of time to see how things go; rescreen; or refer for indepth assessment. In any event, a face-to-face meeting with both parents should be arranged. The following points should be covered:

1	A brief explanation of the purpose of the specific screening
2	A detailed report on the child's performance
3	A specific recommendation for what the team believes should happen next
4	An opportunity for the parents to ask questions and make comments
5	Specific determination of what will occur next and who is responsible
6	A set time for a follow-up contact to check on how things are progressing

The third category, while unpleasant, is straightforward. The parents must be informed of the results immediately and told about the recommendations for referral for indepth assessment. Written parental permission for the assessment will be required. Special care should be taken in this meeting, as this might be the first real indication the parents have that their child has a handicapping condition. Topics to be covered include:

1	A brief explanation of the purpose of the specific screening procedure
2	A detailed report of the child's performance
3	A recommendation for the specific type of assessment, including when, where, who will perform it, and costs, if any
4	An opportunity for parents to ask questions, make comments
5	Detailed outline of what is to happen, when, and who will be responsible. Assuming the recommendation for indepth assessment is accepted by the parents, written permission should be obtained
6	A set time for follow-up. Assessment must be completed within thirty (30) days

One of the major problems with screening procedures is the overall referral and tracking that is required *after* the screening occurs. This activity requires careful planning, good record keeping, and thoughtful use of existing community resources. In setting up a screening program, several important points should be included:

1	Make sure the individuals conducting the screening are well-acquainted with the screening procedures
2	Clearly identify who is responsible for reporting the results to the parents
3	Establish record-keeping procedures that will allow easy tracking of those children who fall into the questionable group and require follow-up as well as those children who are to be assessed
4	Be aware of existing community resources that can be used to obtain indepth assessment
5	Be sensitive to the information needs of the parents
6	Attempt to evaluate the screening procedure in terms of cost effectiveness

Annotated List of Screening Devices

COMPREHENSIVE IDENTIFICATION PROCESS (CIP)

AUTHOR:
R. Reid Zehrback

AVAILABLE FROM:
Scholastic Testing Service, Inc., 480 Meyer Road, Bensenville, Illinois 60106, (312) 766-7150

COPYRIGHT:
1975

COST AND MATERIALS:
Kit $59.95. Includes manual, record folders (35) and booklets (35)

Individual costs:

Symbol Booklet	$6.60
Screening Booklet	4.40
Interviewer's Manual	3.30
Screening Administrator's Manual	4.40
Record Folders (35)	9.62
Speech and Expressive Language Forms	5.77
Observation of Behavior Forms (35)	3.85
Parent Interview Forms (35)	5.77

AGE RANGE:
2½ - 5½ years

PURPOSE:
CIP is an integrated screening program for identifying children 2½ to 5½ years of age who may need special medical, psychological, or educational assistance before they enter kindergarten or first grade.

ADMINISTRATION TIME:
Approximately 30 minutes per child. A skilled screener can test up to four children per hour. Each child is screened individually at the different interview stations as s/he progresses through the screening process.

AREAS OR SUBTESTS:
CIP assesses the whole child in relation to areas of development:

Cognitive-verbal
Fine motor
Gross motor
Speech and expressive language
Hearing
Vision
Social-affective
Medical history

TYPE OF TEST:
Developmental screening test, speech and expressive language screening; can also include hearing and vision screening.

WHO ADMINISTERS:
At least one person directly administering screening items to children (child interviewer). This person (psychologist, speech clinician, teacher or social worker) should be skilled in early childhood screening, evaluation, and education of the handicapped. Other interviewers and the grader may be trained paraprofessionals or volunteers. Hearing and vision screening should be administered by a professional team or a team of paraprofessionals that has been trained by a professional. The speech and expressive language screening may be administered by an interviewer or by a speech clinician. One person on the screening team acts as team leader or screening administrator. This should be a well-trained paraprofessional or a professional.

DENVER PRESCREENING DEVELOPMENTAL QUESTIONNAIRE (DENVER PDQ)

AUTHORS:
William K. Frankenburg, M.D.; William J. Vandoornick, Ph.D.; Theresa N. Liddell, B.A.; Nathan P. Dick, M.S.

AVAILABLE FROM:
LADOCA, Project and Publishing Foundation, East 51st Avenue and Lincoln Street, Denver, Colorado 80216, (303) 629-6379

COPYRIGHT:
1977

COST AND MATERIALS:
Tablets with 100 forms and instructions for administration $3.00. Separate tablets are needed for five age groups: 3-5 months of age; 9-12 months of age; 16-24 months of age; 3-4 years of age; 5-6 years of age

AGE RANGES:
Three months - six years

PURPOSE:
The Denver PDQ is a brief, valid, prescreening questionnaire used to identify those individuals who should be more thoroughly screened with the Denver Developmental Screening Test (DDST). PDQ consists of 97 items. For any given child, only ten age-appropriate items are to be answered by the parent. If a parent reports that the child cannot perform most items, the child is referred for DDST screening. Use of PDQ will reduce the need to administer the more time-consuming DDST on large numbers of children. Only approximately thirty percent (30%) of all children prescreened with the PDQ require further screening.

ADMINISTRATION TIME:
5 - 15 minutes
Individual Test

AREAS OR SUBTESTS:
Questions cover the areas of gross motor, language, fine motor-adaptive and personal-social skills.

TYPE OF TEST:
Prescreening Inventory

WHO ADMINISTERS:
Paraprofessionals

DENVER DEVELOPMENTAL SCREENING TEST (DDST)

AUTHORS:
W. K. Frankenburg, M.D.; J. B. Dodds

AVAILABLE FROM:
LADOCA, Project and Publishing Foundation, East 51st Avenue and Lincoln Street, Denver, Colorado 80216, (303) 629-6379

COPYRIGHT:
1967, 1970, 1975

COST AND MATERIALS:
DDST Reference Manual $4.00. Contains information on standardization, validity, as well as directions for the administration and interpretation of the test.

DDST Kit $7.00. Contains blocks, bells and other materials required to administer the test. Kits do not include a manual or test forms.

Test Forms approximately $2.00 per 100

AGES:
Birth - six years

PURPOSE:
The DDST is a standardized tool used to detect children with potential motor, social, and/or language delays. The DDST uses a series of developmental tasks and milestones to ascertain whether a child's progress is within normal range.

ADMINISTRATION TIME:
10 - 20 minutes
Individual Test

AREAS OR SUBTESTS:
Gross motor, language, fine-motor-adaptive and personal-social skills.

TYPE OF TEST:
Developmental Screening

WHO ADMINISTERS:
Trained paraprofessionals and/or trained volunteers

DEVELOPMENTAL INDICATORS FOR THE ASSESSMENT OF LEARNING (DIAL)

AUTHORS:
Carol D. Mardell; Dorothea S. Goldenberg

AVAILABLE FROM:
Childcraft Education Corporation, 20 Kilmer Road, Edison, New Jersey 08817, (800) 631-5652 (Special Education)

COPYRIGHT:
1972, 1975

COST AND MATERIALS:
DIAL Kit $125.00. Includes manual and record forms, cutting cards, etc., to test 50 children.

Record forms (package of 50) $2.50

Cutting cards (package of 50) $2.50

PURPOSE:
The DIAL was designed as a comprehensive screening device which would quickly and accurately assess all domains of learning for the young child. Development of the DIAL incorporated the following criteria for acceptability:

Screening procedure

Age range 2½ - 5½ years

Individually administered

Expedient and paced for not longer than 30 minutes

Multidimensional in content

Scored objectively

Process oriented but product evaluated also

Culture fair

Normed on large stratified samples

Noncategorical evaluation

ADMINISTRATION TIME:
20 - 30 minutes
Individual Test

AREAS OR SUBTESTS:
Gross motor, fine motor, concepts, communications

TYPE OF TEST:
Prekindergarten screening

WHO ADMINISTERS:
Administration of the DIAL involves the use of a team of professionals, paraprofessionals, and volunteers (optional). Recommendations for appropriate administration include the use of one professional as a DIAL Coordinator, four professionals or paraprofessionals as Operators (to administer items in each area tested), and volunteers (optional).

DEVELOPMENTAL ACTIVITIES SCREENING INVENTORY (DASI)

AUTHORS:
Rebecca F. DuBose; Mary Beth Langley

AVAILABLE FROM:
Teaching Resources Corporation, Boston, Massachusetts, (617) 357-8556

COPYRIGHT:
1977

COST AND MATERIALS:
Kit $39.95. Includes manual and materials

AGE RANGE:
6 - 60 months

PURPOSE:
"The Developmental Activities Screening Inventory is designed as an informal screening measure for children . . . . because it is a nonverbal test, DASI does not penalize children with auditory impairments or language disorders. In addition, adaptations for administering DASI to visually impaired children are clearly specified in the administration procedures."

ADMINISTRATION TIME:
"DASI is not a timed test, therefore, the length of time needed for administration will vary. Some children may complete the test in 25 - 30 minutes; others may require more time."

Individual Test

AREAS OR SUBTESTS:
Area tests include: fine motor, imitative behavior, identification, classification, matching, number concepts, response to commands.

TYPE OF TEST:
Developmental Quotient

WHO ADMINISTERS:
Teachers and trained paraprofessionals

DEVELOPMENTAL SCREENING INVENTORY (DSI)

AUTHOR:
Hilda Knoblock, M.D.

AVAILABLE FROM:
Department of Pediatrics, Albany Medical College, Albany, New York 12208

COST AND MATERIALS:
Materials approximately $2.50. Includes embroidery hoop, aluminum cup, plastic bottle, candies, picture book, crayons and paper, 10 one-inch wooden cubes, and small toy. Test forms (25) $4.50.

AGES:
1 - 18 months

PURPOSE:
The Developmental Screening Inventory (DSI) consists of the systematic application of items from the Gesell Developmental Schedules in the behavioral areas of gross motor, fine motor, adaptive, language and personal-social skills. A maturity level is obtained in each of the five areas and an evaluation is then made of whether the child's score is within the normal, questionable, or abnormal range of development for the current age level.

ADMINISTRATION TIME:
20 - 30 minutes
Individual Test

AREAS OR SUBTESTS:
Adaptive, gross motor, fine motor, language and personal-social skills.

TYPE OF SCORE:
Developmental Quotient

TYPE OF TEST:
Developmental Screening

WHO ADMINISTERS:
Although the DSI was developed for use by physicians and nurses, it can be administered effectively by well-trained paraprofessionals.

YELLOW BRICK ROAD

AUTHOR:
Christine Kallstrom

AVAILABLE FROM:
Learning Concepts, 2501 North Lamar, Austin, Texas 78705, (512) 474-6911

COPYRIGHT:
1975

COST AND MATERIALS:
Kit $39.95. Includes manual, four battery booklets (instructions), testing material, 25 admission tickets (used for scoring)

Additional admission tickets (50) $5.00

AGE RANGE:
Four years, nine months - six years, nine months

PURPOSE:
"The Yellow Brick Road is a screening instrument to identify functional strengths and weaknesses in preschool children."

ADMINISTRATION TIME:
Individually - 45 minutes; group of 24 - two hours (approximately)

AREAS OR SUBTESTS:
Motor (gross and fine), visual, auditory, language

TYPE OF TEST:
Preschool Screening

WHO ADMINISTERS:
Paraprofessionals and volunteers

Assessment refers to two aspects of a continuous process: (1) the determination of eligibility and need for special education and related services; and (2) data collection for Individualized Education Program (IEP) development. Only when we know exactly what a student's strengths and deficits are can we plan to provide appropriate services. The words assessment and evaluation can be used interchangeably. For our purposes, assessment refers to the formal multidisciplinary process of gathering data from a variety of sources which will determine whether a specific handicapping condition exists, and the resulting need for special education, which can then be used in the development of an IEP. For IEP purposes, assessment is the procedure used to determine current levels of performance, yearly instructional goals, and information on individual student learning preferences. Ideally, assessment will provide comprehensive information about the functional level as well as which educational strategies are appropriate.

A single person cannot adequately assess all of a student's specific strengths and problems. One pupil may require tests to diagnose sensory loss, physical ability, and cognitive functioning. The multidisciplinary team (MDT) approach is the solution to the problem of coordinated assessment.

When specialists from many disciplines combine their skills, the district can receive a complete picture of where the student is functioning now, and what kind of programming the child needs. Assigning a MDT leader ensures that no student "slips between the cracks" of the system, while guaranteeing that all needed assessments are conducted in an efficient manner.

Eligibility

When a potentially handicapped child is identified, LEAs are mandated (WAC 392-171-395) to provide assessment services in order to determine if the child is eligible for special education and related services. Thus, regardless of how the child comes to the attention of the LEA (parent referral, community referral, screening, classroom teacher referral, etc.) the same systematic process must then occur:

1. notification to parent of decision to assess
2. formal parental consent for testing
3. review of relevant past records (data and test results)
4. administration and analysis of appropriate and multiple assessment instruments (either by school personnel or other qualified agency personnel)
5. formal determination of eligibility
6. report to parents
7. for those found eligible for special services, the development of an IEP and notification of placement

It is possible that an identified student may indeed have a serious problem that interferes with learning, but is NOT eligible to receive special education and related services. For example, a number of children have considerable achievement deficits in reading or arithmetic, yet do not qualify for special services. Individual LEAs need to establish consistent procedures for reporting this assessment information to the parents (and the student) and to provide some sort of recommendation which will alleviate the problem as much as possible. Additionally, these students need to be systematically tracked for some time, as they are prime candidates for future services. Remember, simply because a child does not meet current eligibility requirements does *NOT* mean the child does not have a significant learning deficit.

Assessment

Documentation of Handicapping Conditions

Once a child has been identified and assessed, eligibility must be determined in order to authorize the expenditure of state excess cost and federal funds for special education and related services. Each student must be eligible within one of the thirteen handicapping conditions described in WAC 392-171. This section describes the documentation required under each handicapping category.

The importance of documentation cannot be overemphasized. Documentation means a *written* record that the criterion is met. The type of documentation varies by handicapping condition but includes:

1. Evidence that the tests were administered and interpreted by qualified professionals and that the student does indeed fall within the specified range or displays the specified deficit(s).
2. Statements or recommendations by physicians, psychologists, communication disorders specialists and others that the student has a specific handicapping condition, displays the specified deficit or behavior, and is in need of special education.
3. Assurances and evidence that other handicapping conditions have been ruled out.
4. Assurances that the tests employed are appropriate to the individual needs of the child with regard to cultural bias, primary language, learning mode, etc.
5. Other items specific to particular categories, e.g., statement of alternatives that have proven ineffective; assurance that classroom observations have been conducted.
6. After the assessment process, the multidisciplinary team (MDT) leader must summarize and sign the conclusions, in addition to the special education director.

The procedures for the documentation and determination of eligibility involve the consideration of many complex issues and cannot be presented in a rigid formula. This section is not designed to answer all of the questions surrounding eligibility determination. Rather, it is a review of the required items as drawn from WAC 392-171-330 through 390.

Eligibility Criteria by Handicapping Condition

Behavioral Disability

Statement of b.d. by psychologist or psychiatrist

Behavioral goals

Intervention techniques attempted

Not socially maladjusted

Not eligible for another category

Eligible

Health/Neurological Impairment

Physician's statement (HI)

Neurological assessment (NI)

Educational deficit (NI)

Not secondary to other handicaps

Eligible

Communication Disorder

Voice

Fluency

Articulation

Language

Hoarseness -- physician's diagnosis

Recommendation by CDS

Eligible

Learning/Language Disability

Significant perceptual deficit

Significant academic deficit

Adjustment for potential

Other handicap(s) ruled out

Statement of LD

MDT confirmation of findings

Eligible

Gross Motor-Orthopedic Handicap

Physician's recommendation

Approval of special education director

Eligible

Multiple Handicaps

Mental retardation

Gross motor and orthopedically handicapped

Hearing impaired

Blind

Overall deficit profound

Eligible

Eligibility Criteria by Handicapping Condition

Mild MR

I.Q. 51-75

Academic delay

Expressive/receptive language delay

Basic academic skills and social independence

Social and adaptive

WAC 375

Eligible

Moderate MR

I.Q. 30-50

Academic delay

Not totally dependent

Self-care skills

WAC 375

Eligible

Severe/Profound MR

I.Q. 30 or below

Academic delay

Close supervision

WAC 375

Eligible

Sensory Impairment

Hearing impaired -- loss exceeds 30 db

Partially sighted -- visual acuity 20/70 to 20/200 in better eye after correction

Partially sighted -- physician's statement

Blind -- visual acuity less than 20/200 in better eye after correction

Blind -- physician's statement

Eligible

Assessment for IEP Development

Once a child is determined eligible for special education and related services, the next procedural step is to develop an IEP. In order to develop an appropriate IEP, the child must be assessed in order to obtain relevant data concerning his/her abilities. Basically, this assessment procedure must answer two questions: (1) What does the student need to learn next; and (2) How does the student learn best?

An important concept to remember is that the assessment process is MORE THAN TESTING. This process includes a wide range of data collection procedures, including review of past records (including test data), questioning individuals who know the child (including the child, whenever possible), observations, and testing. This process also includes data analysis as well as planning for services delivery, instructional procedures, ongoing evaluation, and program identification.

PERFORMING THE ASSESSMENT (OBTAINING NEEDED DATA)

There are a number of procedures that can be used to facilitate the assessment process, both in terms of effectiveness and efficiency. Specifically, this section will focus on using existing data, and using community agencies. Obviously, a third alternative is to use in-school resources.

Use of Existing Data

One of the tragedies of our service delivery system is the duplication of certain activities in the midst of an overall lack of services. For example, many students are assessed, reassessed, and assessed a third time *before* they ever receive services. One agency may require a specific test, while another agency will accept only a different test, both of which provide answers to

the same question (e.g., intelligence tests for eligibility criteria). This is a most wasteful situation in terms of money, personnel, and the child's time. Whenever possible, *USE EXISTING DATA TO ANSWER QUESTIONS.* Only obtain new information when the available information is not viewed as adequate to answer the posed question. Obviously, this argument only makes sense if the assessment procedure is viewed as a question-answer process, rather than a testing process.

Many tests began life as techniques designed to answer specific questions. Someone asked a question; data were collected and an answer was determined. Over time, this procedure became a test and the answer became a score. There were no more questions and no more answers -- only scores! Ask questions and attempt to answer them. Often all the data required to answer the question is already available.

Use of Community Resources

Our communities have numerous resources that can be used to obtain data about children. Sections II and III reviewed many of these resources. When using these resources to obtain data on specific children, we recommend three specific considerations: (1) client eligibility and cost; (2) personalized contact; and (3) specific referrals.

CLIENT ELIGIBILITY AND COST

Client eligibility and cost of the service are often directly related. A large number of services are available at reduced cost or at no cost, depending on the individual (client) being served. For example, Medicaid, Crippled Children's Service, and Maternal and Child Health Services are all available to specific populations of children at no cost. LEAs should determine which services are available from various agencies and which children are eligible for these services. This will help the LEA refer specific children to specific services at little or no cost to the LEA.

PERSONALIZED CONTACT

Personalized contact with the agencies is vital. All local agencies that might serve a child (provide assessment services) should be contacted. Identify contact people in each agency and LEA; these individuals, as they develop a working relationship, should be able to resolve potential conflicts. Also, rules change, new programs are developed, eligibility criteria change, and other developments occur. The contact people should keep one another informed; this kind of informal communication among professional colleagues is the best information system. Additionally, ongoing personal contact makes the task of tracking much easier.

SPECIFIC REFERRALS

Specific referrals are important if the assessment system is not to be overloaded. Too often, children are referred for a "total workup" when there is a need to answer only one specific question. The results of nonspecific referrals are all negative -- wasted professional time, expense, wasted child time -- and keeping those who need the service from receiving it. Care must be taken to specify the exact question one wants answered. Be sure to share other data that might be related to the question. Thus, an audiologist would have to answer the question, "Can Kristin hear well enough to learn phonics?" Included with the request would be teacher observation data on Kristin's auditory performance. This request could be in lieu of a total workup at the speech and hearing clinic. As the specialists collect data to answer the specific question, they may generate other, appropriate questions. Multidisciplinary team assessment can occur normally without a "total workup" for each case.

Tracking

Regardless of how assessment information is obtained, tracking the child through the process is absolutely necessary. A frequent occurrence is to "lose" children in the assessment process or to overlook critical questions. Three factors are important: (1) case manager; (2) specific functions; and (3) timelines.

CASE MANAGER

A case manager should be assigned to each child with the overall responsibility to ensure that the system is functioning. This individual is responsible for initiating the process, making sure all the appropriate questions are asked, coordinating all the team members, keeping in contact with all individuals who are involved in data collection, and in general, organizing the entire process. It is critical that this individual have close contact with all outside agencies that may also be involved with the child.

SPECIFIC FUNCTIONS

Specific functions should be assigned each team member and all those who are requested to provide information. Giving team members specific tasks will enhance participation (an important notion when dealing with parents). When requesting data from other professionals, specific requests result in specific answers. Vague requests result in vague answers. *Be Specific.*

TIMELINES

Timelines allow the team to monitor the overall task and prevents the child from "falling through the cracks". WACs specifically outline timelines for these activities. However, delays do occur and the initial assessment process often far exceeds reasonable time limits. Set timelines and live by them.

DETERMINING CURRENT LEVEL OF PERFORMANCE

This process consists of asking questions about how the student performs in a number of skill areas. Although these skill areas have been broadly defined by P. L. 94-142 and WAC 392-171, the process will vary somewhat according to the needs of the individual child. The process of answering the questions, however, is surprisingly consistent. For each target child, specific content areas are determined. This is accomplished by determining what skill areas are appropriate for the student. For example, a preschool child might be tested in these skill areas: gross motor (ambulation), fine motor (dexterity), communication (language), self-help skills, social skills (including what is commonly referred to as play), and/or cognitive skills. A secondary student might be assessed in reading, math, language arts, and vocational skills. These skill areas are determined by the age of the child and the educational programs available to his/her age peers, as well as by the specific needs of the child.

After deciding on the content areas, the next step is to establish a *sequential* list of critical behaviors for each. This list may be established in many different manners: through developmental pinpoints, scope and sequences from commercial materials, lists of student learning objectives, or from formal tests. The point is that the list include the crucial behaviors and that these behaviors are sequenced in the order that they need to be learned.

The next step is to determine where in each sequence the student is functioning. This is accomplished by collecting data on child performance in the specific area. Remember, this data collection may take many forms, such as reviewing past records, asking people who know the child how she/he is performing, asking specialists to answer the questions (e.g., asking an occupational therapist, "How well can Anne use her fingers?"), observing the child, and testing the child. However, the desired answer to these questions should always be in terms of the child's actual performance in a given area (e.g., Becca can correctly answer four and five place division problems) rather than in words (Becca is dyslexic) or scores (Becca is a 44 in math). Note: Thus words and scores can be used to determine eligibility -- just not current levels of performance.

Data Interpretation

Since this is a team process (teacher, administrative representative, parent, and other appropriate individuals), the individual team members must have faith that the data accurately represent the child's current level of functioning. Believability of data is a personal event, but team consensus, on the other hand, can follow some logical procedures: First, the *entire* team must participate in the process. Second, the individual who collected the actual data should present an opinion as well as the data on which they base the opinion. Thus, each team member may choose to interpret the data differently. Third, all data should represent multiple, rather than single, data points. More recent data should take precedence over older data. Finally, whenever there are discrepancies in data between two or more data points, data from observations in natural situations should be preferred over test results.

This phase of assessment ends when the team is satisfied that they have an accurate statement about the student's current level of functioning. However, throughout the entire educational process, the concept of ongoing assessment ensures that someone is continually asking the question, "What is the child's current level of functioning?"

SETTING YEARLY GOALS

If the functions described above are followed, the procedure for setting yearly goals is straightforward. The crucial content areas for learning have been identified. These areas have been sequenced in terms of critical performance behaviors. The student's current performance level within the established sequence has been determined. Therefore, the logical next step consists of team consensus about what amount of learning is reasonable to expect in the coming year. Obviously, this can only be done *after* the issue of learning style has been determined.

DETERMINING HOW THE CHILD LEARNS BEST

An essential part of assessment is determining what learning style is best for each child. Although learning style may include a wide range of concepts, at a minimum the assessment process should provide data about visual, auditory, health, motor, and motivational aspects of learning. Depending on the individual child these issues will have more or less importance.

VISUAL

Visual abilities of each child should be considered. "Does this child have the ability to process visual information?" If there is any doubt about the answer to this question, formal procedures should be taken. Remember, the Snellen Chart is only accurate for screening for near point vision problems. The rule of thumb must be -- If there is any evidence that vision might be a problem, have a formal check up.

AUDITORY

Auditory capabilities, as with vision, need to be formally questioned for each child. Again, if there is any question about auditory functioning, a formal check up should follow. An additional issue with hearing problems is that of transient or reoccurring difficulties. Due to infection of the middle ear, some children have a *daily* variance in their auditory performance. As a result, many children are overlooked during auditory screening, or even indepth assessment when, in fact, they have a significant hearing loss. Therefore, the team needs to carefully consider the issue of hearing. If a problem is suspected and *NOT* confirmed on formal assessments, a tracking procedure should be developed to recheck the child's hearing in the future.

HEALTH

Health issues are often overlooked during the assessment process. Certainly for the more severely involved students, medical input is crucial. However, for all children, health concerns should be brought up by the team. Questions should include , "Are there any physical limitations on the child?", "Are there any medical procedures that could reduce the handicapping nature of the specific

disability (including the use of medications)?". *Whenever* medications are in use, the team should: (1) determine exactly what medication is given; (2) what *behaviors* does the medication control (increase or decrease); (3) what side effects are possible (in terms of behaviors); (4) when was the last change in level of medication; and (5) when will the dosage be next evaluated. Educators *must* take an active role in monitoring the effects, both desired and undesired, of medications on children in school. (See, for example, Sprague, R., and Werry, J., "Methodology of Psychopharmacological Studies With The Retarded." In N. Ellis (Ed.), *International Review of Research in Mental Retardation*, Vol. 5, New York, Academic Press, 1971, Pages 147-219; Sulzbaucher, S.I., "Psychotropic Medication with Children : An Evaluation of Procedural Biases in Results of Reported Studies," *Pediatrics*, 51, 1973, Pages 513-517; and Sulzbaucher, S.I., "The Learning-disabled or Hyperactive Child : Diagnosis and Treatment." *Journal of American Medical Association*, 234, Dec. 1, 1975, Pages 983-941).

MOTOR

Motor problems, especially in children who have cerebral palsy, must be evaluated, preferably by a physical therapist. At least three questions need to be addressed. First, what are the therapy needs of the child. Second, what can the teacher do on a daily basis in the classroom to provide ongoing best practices for the child. Finally, what is the most appropriate "educational position" in which to place the child to help the child make the desired responses.

MOTIVATIONAL

Motivational considerations vary greatly among children. Although no set of specific questions exists which relate to all children, there are a number of general question categories which should be addressed. How does the child best respond when she/he performs correctly (reinforcement)? How does she/he respond to constructive criticism (error feedback)? Is there a behavior problem? If so, what procedures have been tried in the past? Which were successful? Are there any special considerations that a teacher should be aware of?

Knowing how the child learns best provides the team with important information that needs to be included in the IEP. By asking these questions and obtaining information as indicated, the team is often able to greatly enhance the educational program.

Summary Analysis of Assessment Data

Washington State requires that a summary analysis of assessment data be developed based on the data collected during a student's evaluation. The summary analysis should be more than simply a listing of tests employed and scores obtained. It should include:

1. Written identification of the student's specific handicapping condition.
2. A description of the extent of special education and related services the student needs, if any. (Some of this information may be contained in the IEP).
3. A discussion of the significance of the test results in determining the student's eligibility.
4. A record of the use of professional judgment (if needed) and reasons supporting the judgment.
5. Signature of the multidisciplinary team leader and the special education director or designee and the date.

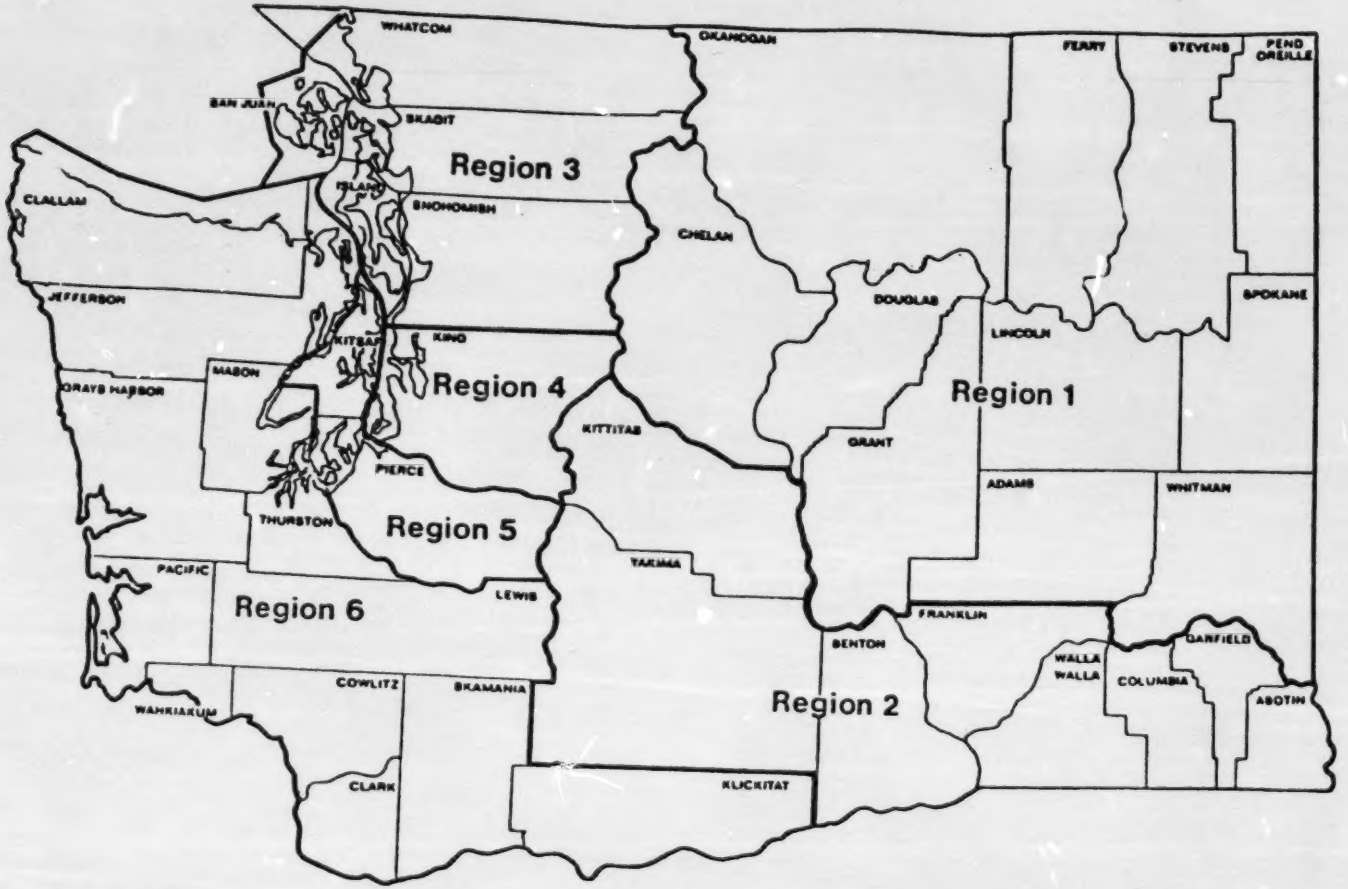
REFERENCES

Cross, L. and Goin, K., *Identifying Handicapped Children : A Guide to Casefinding, Screening, Diagnosis, Assessment, and Evaluation*, New York, Walker and Company, 1977.

Huntington, D., *Developmental Review in the Early and Periodic Screening, Diagnosis, and Treatment Program*, DHEW Publication No. (SRS) 500-76-0510, Washington, D.C., 1977.

Meier, J.H., *Screening and Assessment of Young Children at Developmental Risk*, U. S. Government Printing Office, No. (05) 73-90, Washington, D.C., 1973.

DSHS Regions



Directory of Services

DSHS Regional Offices

REGION 1 OFFICE

W.1101 College,Room 360
Spokane, WA 99201
456-4487

REGION 2 OFFICE

(1116 W. Lincoln)
P. O. Box 2628
Yakima, WA 98907
575-2290

REGION 3 OFFICE

1509 - 32nd Street
Everett, WA 98201
259-5751

REGION 4 OFFICE

(130 Andover Park E.,
Tukwila)
U.S. Mailing Address:
P. O. Box C88490
Tukwila Branch
Seattle, WA 98188
721-4050

REGION 5 OFFICE

1201 South Proctor
Tacoma, WA 98405
593-2300

REGION 6 OFFICE

(2535 N. E. Kresky Road)
P. O. Box 239
Chehalis, WA 98532
748-6616

Social Security (SSI) Offices

ABERDEEN
(Olympia)
(421 W. State Street)
P. O. Box 810
Aberdeen, WA 98520

BELLEVUE
127 - 107th Ave. N. E.
Bellevue, WA 98004

BELLINGHAM
(1919 Broadway)
P.O. Box 36
Bellingham, WA 98225

BREMERTON
(900 Pacific Avenue)
P. O. Box 29
Bremerton, WA 98310

CHEHALIS
(Olympia)
(409 S. Market Blvd.)
P. O. Box 1107
Chehalis, WA 98532

EVERETT
(2940 Norton Avenue)
P. O. Box 5227
Everett, WA 98206

LONGVIEW
(Vancouver)
(828 - 12th Avenue)
P. O. Box 2009
Longview, WA 98632

LYNNWOOD
(Everett)
(19502 - 56th Ave. W.)
P. O. Box 897
Lynnwood, WA 98036

MOUNT VERNON
(Bellingham)
(1601 E. College Way)
P. O. Box 399
Mount Vernon, WA 98273

OLYMPIA
(3700 Martin Way
Suite 108)
P. O. Box 608
Olympia, WA 98507

PASCO
(Yakima)
(330 W. Clark Street)
P. O. Box 492
Pasco, WA 99301

PORT ANGELES
(Bremerton)
107 E. 8th Street
Port Angeles, WA 98362

PULLMAN
(Lewiston, Idaho)
Professional Mall
S.E. 1205 Johnson Ave.
Pullman, WA 99163

PUYALLUP
(Tacoma)
803 E. Main Street
Puyallup, WA 98371

RENTON
(Bellevue)
(307 Rainier Ave. S.)
P. O. Box 1037
Renton, WA 98055

SEATTLE
230 Fairview Ave. N.
Seattle, WA 98109

BURIEN
(Bellevue)
15223 - 4th Ave. S.W.
Seattle, WA 98166

NORTH (SEATTLE)
(12059 - 15th St. N.E.)
P. O. Box 25768
Seattle, WA 98125

SOUTH (SEATTLE)
2605 South McClellan St.
Seattle, WA 98144

WEST (SEATTLE)
5242 California Ave. S.W.
Seattle, WA 98136

SPOKANE
W. 708 Boone Avenue
Spokane, WA 99201

TACOMA
(1208 S. 10th St.)
P. O. Box 5276
Tacoma, WA 98405

VANCOUVER
(509 W. 8th St.)
P. O. Box 249
Vancouver, WA 98660

WALLA WALLA
(335 S. 2nd St.)
P. O. Box 947
Walla Walla, WA 99362

WENATCHEE
(301 Yakima St.)
P. O. Box 1428
Wenatchee, WA 98801

YAKIMA
(101 N. 6th Ave.)
P. O. Box 2188
Yakima, WA 98907

County Health Departments

ADAMS COUNTY
HEALTH DISTRICT
210 West Boardway
Ritzville, WA 99169
659-1740

ASOTIN COUNTY HEALTH
DEPARTMENT
431 Elm
Clarkston, WA 99403
758-3344

BELLINGHAM-WHATCOM
HEALTH DISTRICT
(509 Girard St)
P.O. Box 935
Bellingham, WA 98225
676-6720

BENTON-FRANKLIN HEALTH
DISTRICT
1005 Goethals Drive
Richland, WA 00352
943-2614

PROSSER OFFICE
1132 Meade
Prosser, WA 99350
786-1633

PASCO OFFICE
1218 North 4th
Health Center
Pasco, WA 99301

BREMERTON-KITSAP COUNTY
HEALTH DEPT.
109 Austin Drive
Bremerton, WA 98310
478-5235

CHELAN-DOUGLAS HEALTH
DISTRICT
316 Washington Street
Wenatchee, WA 98801
663-2105

CLALLAM COUNTY
HEALTH DEPARTMENT
903 East Caroline
Port Angeles, WA 98362
452-3838

CLARK (See S.W. Wash Health Dist.)

COLUMBIA COUNTY HEALTH DEPARTMENT
114 North Second
Dayton, WA 99328
382-2181

COWLITZ-WAHKIAKUM HEALTH DISTRIC
(1615 Hudson)
P.O. Box 458
Longview, WA 98632
425-7400

DOUGLAS (See CHELAN-DOUGLAS HEALTH DIST.)

FRANKLIN (See Benton-Franklin Health Dept.)

GARFIELD COUNTY HEALTH DEPARTMENT
(189 - 11th Street)
P.O. Box 130
843-3412

GRANT COUNTY HEALTH DISTRICT
(County Courthouse)
P.O. Box 816
Ephrata, WA 98823
754-2011 (Ext. 372)

GRAYS HARBOR-PACIFIC HEALTH DISTRICT
223 Finch Building
Aberdeen, WA 98520
532-8631

SOUTH BEND OFFICE
SOUTH BEND, WA 98586
875-5594

ISLAND COUNTY HEALTH DEPARTMENT
(Courthouse Annex)
P.O. Box 700
Coupeville, WA 98239
678-5111

CAMANO ISLAND OFFICE
121 N.E. Camano Drive
Camano Island, WA 98292
387-3443

JEFFERSON COUNTY HEALTH DEPARTMENT
Multiservices Building
2nd Floor
802 Sheridan
Port Townsend, WA 98368
385-0722

KING-SEATTLE (See SEATTLE-KING CO. HEALTH DEPARTMENT)

KITSAP (See BREMERTON-KITSAP CO. HEALTH DISTRICT)

KITTITAS COUNTY HEALTH DEPT.
507 Nanum
Ellensburg, WA 98926
925-1465

KLICKITAT (See S.W. Wash. Health Dist.)

LEWIS COUNTY HEALTH DISTRICT
(Health Services Bldg)
P.O. Box 706
Chehalis, WA 98532
748-2121 (Ext. 222)

LINCOLN COUNTY HEALTH DEPARTMENT
Nursing Office
(507 - 7th Avenue)
P.O. Box 215
725-1001

MASON COUNTY HEALTH DEPARTMENT
110 West K
Shelton, WA 98584
426-4407

NORTHEAST TRI-COUNTY HEALTH DISTRICT
(Courthouse, Room 213)
Box 270
Colville, WA 99114
684-5048

FERRY COUNTY OFFICE
P.O. Box 584
Republic, WA 99116
775-3161

PEND OREILLE COUNTY OFFICE
(South 230 Garden Avenue)
P.O. Box 490
Newport, WA 99156
447-3175

OKANOGAN COUNTY HEALTH DEPARTMENT
(Hancock Building)
P.O. Box 231
Okanogan, WA 98840
422-3867

PIERCE (See TACOMA-PIERCE CO. HEALTH DEPARTMENT)

SAN JUAN COUNTY HEALTH DEPARTMENT
P.O. BOX 607
Friday Harbor, WA 98250
378-4474

CENTRAL DISTRICT HEALTH CENTER
Room 1000
Public Safety Building
Seattle, WA 98104
625-2571

EAST DISTRICT HEALTH CENTER
2424 - 156th Avenue, N.E.
Bellevue, WA 98004
885-1278 or 747-1760

NORTH DISTRICT HEALTH CENTER
10501 Meridian Avenue N.
Seattle, WA 98133
363-4765

SOUTHEAST DISTRICT HEALTH CENTER
3001 N.W. 4th St.
Renton, WA 98055
228-2620

AUBURN OFFICE
20 Auburn Avenue
Auburn, WA 98002
852-8400

SOUTHWEST DISTRICT HEALTH CENTER
10821 8th S.W.
Seattle, WA 98146
244-6499

SKAGIT COUNTY HEALTH DEPARTMENT
Courthouse Admin. Bldg.
Mount Vernon, WA 98273
336-9380

SKAMANIA (See S.W. Wash. Health Dist.)

SNOHOMISH HEALTH DISTRICT
Courthouse
Everett, WA 98201
259-9440

SOUTHWEST WASHINGTON HEALTH DISTRICT
2000 Fort Vancouver Way
Vancouver, WA 98663
695-9215

KLICKITAT COUNTY OFFICE
(216 West Main)
P.O. Box 131
Goldendale, WA 98620
773-4565

STEVENSON OFFICE
SKAMANIA COUNTY
(0.96 Mile Post)
P.O. Box 162
Stevenson, WA 98648
427-5138

WHITE SALMON OFFICE
KLICKITAT COUNTY
(130 East Jewett)
P.O. Box 427
White Salmon, WA 98672
493-1558

SPOKANE COUNTY HEALTH DISTRICT
West 1101 College Avenue
Spokane, WA 99201
456-3630

SOUTHWEST CENTER
115 College
Cheney, WA 99004
235-6327

TACOMA-PIERCE COUNTY HEALTH DEPARTMENT
3629 South "D" St.
Tacoma, WA 98408
593-4534

THURSTON COUNTY HEALTH DEPARTMENT
529 S.W. Fourth
Olympia, WA 98501
753-8067

WAHKIAKUM (See Cowlitz-Wahkiakum Health Dist.)

WALLA WALLA COUNTY-CITY HEALTH DIST.
(310 W. Poplar)
P.O. Box 1753
Walla Walla, WA 99362
525-6730

WHITMAN COUNTY HEALTH DEPARTMENT
Public Service Bldg.
N. 310 Main St.
Calfax, WA 99111
397-3471

YAKIMA COUNTY HEALTH DISTRICT
104 N. First St.
Yakima, WA 98901
575-4040

SUNNYSIDE OFFICE
216 S. 8th St. Ext. N.
Sunnyside, WA 98944
575-2317

Head Start

BENTON-FRANKLIN COUNTIES

BENTON-FRANKLIN
HEAD START
805 Williams, Room 132
Richland, WA 99352
946-4639

RICHLAND HEAD START
505 McMurray
Richland, WA 99352
943-1071

KENNEWICK HEAD START
304 West 6th
Kennewick, WA 99336

PASCO HEAD START
40th and West Court
Pasco, WA 99301
547-5723

CHELAN-DOUGLAS COUNTIES

WENATCHEE-EASTMONT
HEAD START
1408 Washington
Wenatchee, WA 98801
663-5179

CLALLAM-JEFFERSON COUNTIES

JEFFERSON COUNTY CENTER
(Lawrence and Tyler)
P. O. Box 553
Port Townsend, WA 98368
385-0525

CLALLAM CENTER
Assembly of God Church
W. 8th and Pine
Port Angeles, WA 98362
452-8470

COWLITZ COUNTY

LOWER COLUMBIA
HEAD START
1600 Maple
Longview, WA 98632
577-2388

KLICKITAT COUNTY

GREATER GOLDENDALE
CHILD SERVICES
(East Darland and Wilbur)
P. O. Box 966
Goldendale, WA 98620
773-5711

SNOHOMISH COUNTY

SNOHOMISH COUNTY
HEAD START
(2718 Oakes)
P. O. Box 1185
Everett, WA 98206

FOURTH PARK CENTER
4526 Federal
Everett, WA 98204

SOUTH CENTER
Building 600
Paine Field Complex
Everett, WA 98204

SPOKANE COUNTY

SPOKANE COUNTY
HEAD START
Spokane-Central and
Field School
North 4521 Ask
Spokane, WA 99205
456-3948

MISSION PARK DAY CARE
North 1216 Superior
Spokane, WA 99202
456-6348

STEVENS, FERRY, AND PEND OREILLE COUNTIES

NORTHEAST WASHINGTON
HEAD START
Box 328
Colville, WA 99114
684-2515

CUSICK HEAD START
Cusick Grade School
Cusick, WA 99119

METALINE FALLS
HEAD START
Pend Oreille Apartments
Metaline Falls,
WA, 99158
446-4683

CHEWELAH HEAD START
American Legion Hall
Chewelah, WA 99109

WALLA WALLA COUNTY

WALLA WALLA HEAD START
Paine School
South 4th
Walla Walla, WA 99362
529-5840

WHATCOM COUNTY

BELLINGHAM HEAD START
AND LDO
(2001 "H" Street)
P. O. Box 159
Bellingham, WA 98225

LUMMI HEAD START
Kwina Road
Bellingham, WA 98225
734-8180 (Exts. 260,215)

YAKIMA COUNTY

YAKIMA HEAD START
33 South Second Avenue
Yakima, WA 98902
575-2897

RUTH CHILDS SCHOOL
2000 South 18th Street
Yakima, WA 98903
575-3290

LINCOLN SCHOOL
P. O. Box 754
Sunnyside, WA 98944
837-5991

ST. PAUL SCHOOL
11th and Chestnut
Yakima, WA 98902

BUENA SCHOOL
P. O. Box 338
Buena, WA 98921
865-3938

McKINLEY SCHOOL
Fort Road
Toppenish, WA 98948
865-4222

CLARK COUNTY

HEAD START
OF CLARK COUNTY
3405 N.E. 52nd Street
Vancouver, WA 98661
694-3377

EAST COUNTY
1124 S. E. Everett Road
Camas, WA 98607
834-5121

EVERGREEN I AND II
9810 N. E. 76th Street
Vancouver, WA 98662
892-2111

HAZEL DELL-EAST AND
HAZEL DELL-WEST
1220 N. E. 68th Street
Vancouver, WA 98665
695-6159

RIDGEFIELD CENTER
414 Pioneer
Ridgefield, WA 98642

BATTLEGROUND CENTER
18400 N.E. 158th Street
Brush Prairie, WA 98606
892-4705

LIESER
8310 MacArthur Boulevard
Vancouver, WA 98664
695-7248

VANCOUVER CENTER
3114 Fourth Plain Blvd.
Vancouver, WA 98661
694-2483

GRANT COUNTY

EPHRATA-SOAP LAKE
HEAD START
(400 Maringo Road)
P. O. Box 298
Ephrata, WA 98823
754-3341

GRAYS HARBOR COUNTY

GRAYS HARBOR HEAD START
207 South Chehalis
Aberdeen, WA 98520
533-5100

GRAYS HARBOR HEAD START
900 Cleveland
Aberdeen, WA 98520
532-6154

KITSAP COUNTY

ELLENSBURG CENTER
(101 West 12th
Grace Episcopal Church)
P. O. Box 835
Ellensburg, WA 98926
925-2262

CLE ELUM CENTER
Assembly of God Church
Third and Montgomery
Cle Elum, WA 98922
674-5187

MASON-THURSTON COUNTIES

OLYMPIA HEAD START CNTR.
21st and Washington
Olympia, WA 98501
357-7714

EVERGREEN VILLAGES
505 North Division N.W.
Olympia, WA 98502
943-5505

RAINIER HEAD START
Alaska Street
Rainier, WA 98576
446-2555

ROCHESTER
First Methodist Church
Rochester, WA 98579
253-5000

SHELTON HEAD START
1912 King Street
Shelton, WA 98584
426-2898

SKOKOMISH HEAD START
Skokomish Tribal Center
Hoodsport, WA 98548
877-5268

OKANOGAN COUNTY

OKANOGAN COUNTY
HEAD START
P. O. Box 1844
Omak, WA 98841
826-2466

OMAK HEAD START
17 South Ash
Omak, WA 98841
826-2466

UPPER VALLEY OUTREACH
R. R. #1
Tonasket, WA 98855

PIERCE COUNTY

TACOMA PUBLIC SCHOOLS
(South 8 Tacoma Avenue)
P. O. Box 1357
Tacoma, WA 98401
593-6952

WAINWRIGHT
130 Alameda
Tacoma, WA 98406
564-5720

WILLARD
3201 South "D"
Tacoma, WA 98408

McCARVER
2111 South "G"
Tacoma, WA 98405

JEFFERSON
4302 North 13th
Tacoma, WA 98406
752-7711

LISTER
2106 East 44th
Tacoma, WA 98404
475-5300

ROGERS
1301 East 34th
Tacoma, WA 98404
272-4256

ROOSEVELT
1301 East 34th
Tacoma, WA 98404
383-4083

SEWARD SCHOOL
4902 South Alaska
Tacoma, WA 98408
475-6770

STANLEY
1712 South 17th
Tacoma, WA 98405

SKAGIT COUNTY

SKAGIT COUNTY HEAD START
204 West Montgomery
Mount Vernon, WA 98273
428-1102

MOUNT VERNON HEAD START
1510 East Kinkaid Street
Mount Vernon, WA 98273
424-7334

SWINOMISH HEAD START
Swinomish Tribal Center
La Conner, WA 98257
466-3918

BURLINGTON HEAD START
% 204 West Montgomery
Mount Vernon, WA 98273
428-1102

ANACORTES HEAD START
Whitney School
Anacortes, WA 98221
293-2720

SEDRO WOOLLEY HEAD START
Mary Purcell School
Sedro Woolley, WA 98284
855-0450

Home Health Agencies

ASSURED HOME
HEALTH AGENCY
522 North Iron
Centralia, WA 98531
736-1146

BALLARD COMM. HOSPITAL
HOME HEALTH AGENCY
5409 Barnes Avenue
Seattle, WA 98107
782-2700

BENTON-FRANKLIN
HEALTH DISTRICT
HEALTH DEPARTMENT
1005 Goethals Drive
Richland, WA 98352
943-2614

BREMERTON-KITSAP COUNTY
HEALTH DEPARTMENT
109 Austin Drive
Bremerton, WA 98310
478-5262

CENTRAL WA. HEALTH
SERVICES ASSOCIATION
HOME HEALTH SERVICES
(Rosewood at Red Apple
Road) P. O. Box 1710
Wenatchee, WA 98801
662-1511 (Ext. 349)

CLALLAM COUNTY DEPT.
OF HEALTH HOME HEALTH
SERVICES
903 East Caroline St.
Port Angeles, WA 98362

COMMUNITY HOME
HEALTH AGENCY
900 Fir Suite 2R
Longview, WA 98632
425-8510

COMMUNITY HOME
HEALTH CARE
2627 Eastlake Ave. E.
Seattle, WA 98102
322-0930 or 322-5360

COMMUNITY HOMEWELL
2021 College Way
Suite 220
Mount Vernon, WA 98273
424-3106

COWLITZ-WAHKIAKUM
COUNTIES HEALTH DISTRICT
HOME HEALTH AGENCY
1615 Hudson
Longview, WA 98626
425-7400

GOOD SAMARITAN HOSPITAL
HOME HEALTH AGENCY
407 - 14th Ave. S. E.
Puyallup, WA 98371
848-6661

GRAYS HARBOR-PACIFIC
HOME HEALTH
223 Finch Building
Aberdeen, WA 98520
532-8631

GROUP HEALTH COOPERATIVE
HOME HEALTH AGENCY
200 - 15th Avenue East
Seattle, WA 98102
326-6081

HOME HEALTH SERVICES
OF PUGET SOUND
5828 Roosevelt Way N.E.
Seattle, WA 98115
524-7145

HOME HEALTH CARE
OF ISLAND COUNTY
P. O. Box 548
Coupeville, WA 98239
678-6062

N.E.W. HEALTH PROGRAMS
HOME HEALTH AGENCY
(103 North Fourth St.E.)
P. O. Box 197
Chewelah, WA 99109
935-6001

OKANOGAN REGIONAL HOME
HEALTH CARE AGENCY, INC.
(321 Pine Street)
P. O. Box 302
Okanogan, WA 98840
422-6721

SEATTLE-KING COUNTY
VISITING NURSE SERVICE
557 Roy Street
Seattle, WA 98109
282-9800

SOUND HOME HEALTH
SERVICES OF THURSTON AND
MASON COUNTIES
(1107 West Harrison)
P. O. Box 1156
Olympia, WA 98507
754-9166

S. W. WASHINGTON
HEALTH DISTRICT
2000 Fort Vancouver Way
Vancouver, WA 98663
695-9215

SPOKANE VISITING
NURSE ASSOCIATION
1504 Northwest Blvd.
Spokane, WA 99205
326-6923

ST. ELIZABETH HOSPITAL
110 South 9th Avenue
Yakima, WA 98902
575-5000

ST. LUKE'S MEMORIAL
HOSPITAL HOME HEALTH
AGENCY
South 771 Cowley Street
Spokane, WA 99210
838-4771

ST. MARY'S COMMUNITY
HOSPITAL HOME HEALTH
AGENCY
401 West Poplar
Walla Walla, WA 99362
525-3320

TACOMA-PIERCE COUNTY
HEALTH DEPARTMENT
3629 South D Street
Tacoma, WA 98408
593-4160 and 592-4180

VISITING NURSE ASSOCIA-
TION OF SNOHOMISH COUNTY
(232 Olympic Boulevard)
P. O. Box 1447
Everett, WA 98206
258-4441

VISITING NURSE AND HOME
HEALTH CARE AGENCY OF
WHATCOM COUNTY
1310 Broadway, Suite 2D
Bellingham, WA 98225
734-9210

YAKIMA HEALTH DISTRICT
HOME HEALTH AGENCY
104 North First Street
Yakima, WA 98901
575-4278

DSHS Institutions

INSTITUTIONS FOR MENTALLY RETARDED

FIRCREST SCHOOL
15230 - 15th N. E.
Seattle, WA 98155
364-0300

INTERLAKE SCHOOL
P. O. Box B
Medical Lake, WA 99022
299-3111

LAKELAND VILLAGE
P. O. Box 200
Medical Lake, WA 99022
299-3131

RAINIER SCHOOL
P. O. Box 600
Buckley, WA 98321
829-1111

YAKIMA VALLEY SCHOOL
P. O. Box 238
Selah, WA 98942
697-7272

FRANCES HADDON MORGAN
CHILDREN'S CENTER
6th and Marion Avenue
Bremerton, WA 98310
478-4824

INSTITUTIONS FOR THE BLIND, DEAF AND CEREBRAL PALSY CENTER

STATE SCHOOL
FOR THE BLIND
2214 East 13th
Vancouver, WA 98661
694-1516

STATE SCHOOL
FOR THE DEAF
611 Grand Boulevard
Vancouver, WA 98661
694-8491

STATE CEREBRAL PALSY
CENTER
2001 N. E. 160th
Seattle, WA 98155
362-5656

DSHS Community Services Offices

REGION I

DELINQUENCY PREVENTION SERVICES

NORTH CENTRAL WASHING-
TON CENTER FOR YOUTH
SERVICES
116 South Mission
Suite #1
Wenatchee, WA 98801
662-6310

SPOKANE CENTER FOR YOUTH
SERVICES
2610 Northwest Boulevard
Spokane, WA 99205
456-3270

COMMUNITY SERVICE
OFFICES (CSO)

COLFAX CSO
(300 N. Mill)
P. O. Box 149
Colfax, WA 99111
397-4326

EPHRATA CSO
(Grant-Adams Adm. Unit)
(229 - 1st N. W.)
P. O. Box 638
Ephrata, WA 98823
754-2427

MOSES LAKE BRANCH CSO
(Vista Village Shopping
Center, Moses Lake)
Address Mail:
% Ephrata CSO
765-9176

OTHELLO CSO
107 South First
Othello, WA 99344
488-9673

OMAK-OKANOGAN CSO
(800 Valley Way)
Rt. 1, Box 24-E
Omak, WA 98841
826-0082

NESPELEM BRANCH CSO
(Indian Health Serv
Services, Nespelem, WA
99155)
Address Mail:
% Omak-Okanogan CSO
634-4211

SPOKANE/LINCOLN CSO
(1427 W. Gardner Avenue)
P. O. Box 2868
Spokane, WA 99220
456-3096

BROADWAY BUILDING
(W. 1303 Broadway)
Address Mail:
% Spokane CSO

PHILLIPS BUILDING
(N. 1210 Post)
Address Mail:
% Spokane CSO

POST STREET BUILDING
(N. 1212 Post)
Address Mail:
% Spokane CSO

DAVENPORT CSO
(8th and Park)
P. O. Box 640
Davenport, WA 99122
725-5501

TRI-COUNTY COMMUNITY
SERVICE CENTER
COLVILLE CSO
(1100 S. Main)
Rt. 3
Colville, WA 99114
684-5261

NEWPORT CSO
(4th and Warren)
P. O. Box 570
Newport, WA 99156
447-3192

REPUBLIC CSO
P. O. Box 626
Republic, WA 99166
Administrator (Offic-
ed at Colville CSO)
775-3155

WENATCHEE CSO
(325 N. Chelan)
P. O. Box 3088
Wenatchee, WA 98801
623-9511

REGION 2

DELINQUENCY PREVENTION SERVICES

YAKIMA CENTER FOR YOUTH SERVICES B 39-5
(2515 Main Street Union Gap)
P. O. Box 9788
Yakima, WA 98907
575-2179

WALLA WALLA CENTER FOR YOUTH SERVICES
(206 W. Poplar)
P. O. Box 517
Walla Walla, WA 99362
527-4362

ELLENSBURG CENTER FOR YOUTH SERVICES
(521 E. Mountain View)
P. O. Box 366
Ellensburg, WA 98926
929-9834

COMMUNITY SERVICES OFFICES (CSO)

CLARKSTON CSO
720 - 6th Street
Clarkston, WA 99403
758-5537

ELLENSBURG CSO
(521 Mountain View)
P. O. Box 366
Ellensburg, WA 98926
925-9834

PASCO CSO
(800 W. Court)
P. O. Box 931
Pasco, WA 99301
545-2247

RICHLAND OUTSTATION
(805 Williams Blvd.)
P. O. Box 495
Richland, WA 99352
946-4171

SUNNYSIDE CSO
(208 S. 8th Street)
P. O. Box 276
Sunnyside, WA 98944
837-3531

PROSSER OFFICE
(600 S. 8th)
Address Mail:
% Sunnyside CSO
786-1636

TOPPENISH CSO
(306 Bolin Drive)
P. O. Box 470
Toppenish, WA 98938
865-2805

WALLA WALLA CSO
(206 W. Poplar)
P. O. Box 517
Walla Walla, WA 99362
527-4331

DAYTON OFFICE
(215 W. Clay Street)
Address Mail:
% Walla Walla CSO
382-2503

YAKIMA CSO
(Social Services)
P. O. Box 9788
Yakima, WA 98909
(Information)
575-2150
(Valley Mall, 2515 Main Street Union Gap, WA 98903)

MULTI-SERVICE CENTER OFFICE B 39-3
(1211 S. 7th Street, Yakima)
Address Mail:
% Yakima CSO
558-2253

YAKIMA CSO
(Financial Eligibility)
(315 N. 5th Avenue, Yakima)
P. O. Box 9788
Yakima, WA 98903
(Information)
575-2000

REGION 3

DELINQUENCY PREVENTION SERVICES

EVERETT CENTER FOR YOUTH SERVICES
302 Commerce Building
1803 Hewitt Avenue
Everett, WA 98201
259-8515

MOUNTLAKE TERRACE CENTER FOR YOUTH SERVICES
21309 - 44th Avenue West
Mountlake Terrace, WA 98048
775-5555

COMMUNITY SERVICE OFFICES (CSO)

BELLINGHAM CSO
(222 Unity Street)
P. O. Box 639
Bellingham, WA 98225
676-2000

LUMMI BRANCH OFFICE
(Lummi Tribal Center, Kwina Road, Marietta, WA 98268)
Address Mail:
% Bellingham CSO

EVERETT CSO
(2809 Grand)
P. O. Box 5127
Everett, WA 98206
259-8484

MOUNT VERNON CSO ADMINISTRATIVE
(Reep Building, 1220 Memorial Highway)
P. O. Box 310
Mount Vernon, WA 98273
428-1400

MOUNT VERNON CSO FINANCIAL & SUPPORTIVE SERVICES
(Brenner Building, 2121 College Way)
P. O. Box 310
Mount Vernon, WA 98273
428-1400

ANACORTES BRANCH OFFICE
(2801 Commercial)
P. O. Box 568
Anacortes, WA 98221
293-2176

OAK HARBOR BRANCH OFFICE
(1397-F Midway Blvd.)
P. O. Drawer PP
Oak Harbor, WA 98277
675-5928

MOUNTLAKE TERRACE CSO
21309 - 44th Avenue West
Mountlake Terrace, WA 98043
775-5555

REGION 4

CENTRALIZED SERVICES OFFICE
2809 - 26th Avenue S.
Seattle, WA 98144
Information and Referral (General)
721-4105

Children's Protective Services
721-4138

Crisis Intervention
721-4115

CPS Community Affairs Consultant
721-4559

Day Care Referral
721-4110

Regional Medical Unit
721-4210

COMMUNITY SERVICE OFFICES (CSO)

BELLEVUE CSO
(Information)
15027 Main Street
Bellevue, WA 98007
455-7030

BURIEN CSO
(Information)
(149 South 140th Street)
P. O. Box 66532
Burien, WA 98166
464-7120

WEST SEATTLE BRANCH OFFICE
(6330 - 35th S.W.)
Main to Burien CSO
(General Information)
464-6156

CAPITOL HILL CSO
1700 East Cherry
Seattle, WA 98122
464-7250

PIONEER SQUARE BRANCH OFFICE
2106 - 2nd Avenue
Seattle, WA 98121
464-6692

KENT CSO
(21851 - 84th Avenue S.)
P. O. Box 848
Kent, WA 98031
872-6300

FEDERAL WAY CSO
(1617 South 324th Street)
P. O. Box 3438
Federal Way, WA 98003
838-9000

MUCKLESHOOT OUTSTATION
(38811 S. E. 172nd,
Auburn)
Mail to Kent CSO
839-3311

KING NORTH CSO
907 N. W. Ballard Way
Seattle, WA 98107
545-1011

RAINIER CSO
2809 - 26th Avenue South
Seattle, WA 98144
721-4105

REGION 5

COMMUNITY SERVICES FOR CHILDREN

BREMERTON CENTER FOR YOUTH SERVICES
3421 - 6th Street
Bremerton, WA 98310
478-4510

COMMUNITY SERVICE OFFICES (CSO)

BREMERTON CSO
4810 Audo Center Way
Bremerton, WA 98310
478-4995

HILLTOP CSO
1210 - 6th Avenue
Tacoma, WA 98405
593-2950

PACIFIC CENTER CSO
9201 Pacific Avenue
Suite 250
Tacome, WA 98444
593-2840

PUYALLUP CSO
1004 East Main Street
Puyallup, WA 98371
593-8600

TACOMA AVENUE CSO
1301 Tacoma Avenue South
Tacoma, WA 98402
593-2600

REGION 6

COMMUNITY SERVICES FOR CHILDREN

(2025 N.E. Dresky Road)
P. O. Box 359
Chehalis, WA 98532
748-4438

GRAYS HARBOR CENTER FOR YOUTH SERVICES
207 South M Street
Aberdeen, WA 98520
533-9295

PORT ANGELES CENTER FOR YOUTH SERVICES
540 East 8th
Port Angeles, WA 98362
457-9252

TWIN-CITY CENTER FOR YOUTH SERVICES
(2025 N. E. Kresky Road)
P. O. Box 359
Chehalis, WA 98532
748-4438

WILLIPA BAY CENTER FOR YOUTH SERVICES
(710 W. Robert Bush Dr.)
P. O. Box 5
South Bend, WA 98586
875-6492

COMMUNTIY SERVICE OFFICES (CSO)

ABERDEEN CSO
(405 W. Wishkah)
P. O. Box 189
Aberdeen, WA 98520
533-9256

ELMA CSO
Mail to Aberdeen CSO

CHEHALIS CSO
(2025 N. E. Kresky Road)
Chehalis, WA 98532
748-0041

LONGVIEW CSO
1116 - 14th Avenue
Longview,WA 98632
577-2001

CATHLAMET CSO
P. O. Box 38
Cathlamet, WA 98612
Mail to Longview

OLYMPIA CSO
(5000 Capitol Blvd.)
P. O. Box 1816
Olympia, WA 98504
753-5983

PORT ANGELES CSO
(716 South Chase)
P. O. Box 2148
Port Angeles, WA 98362
452-3381

PORT TOWNSEND CSO
(802 Sheridan)
P. O. Box 544
Port Townsend, WA
98368
385-0200

FORKS CSO
P. O. Box 628
Forks, WA 98331
Mail to Port Angeles
374-2257

SHELTON CSO
(110 W. "K" Street)
P. O. Box 519
Shelton, WA 98584
426-5511

SOUTH BEND CSO
(724 W. Robert Bush Drive)
P. O. Box 87
South Bend, WA 98586
875-6501

VANCOUVER CSO
(613 W. Evergreen)
P. O. Box 1998
Vancouver, WA 98663
696-6221

ORCHARDS CSO
(10401 N.E. Fourth Plain Boulevard)
P. O. Box 1814
Vancouver, WA 98663
Mail to Vancouver
696-6707

WHITE SALMON CSO
(Lincoln & Main)
P. O. Box 126
White Salmon, WA 98672
493-1012

GOLDENDALE CSO
(106 E. Main)
P. O. Box 185
Goldendale, WA 98620
Mail to White Salmon
773-5835

STEVENSON CSO
(200 Second Street)
P. O. Box 326
Stevenson, WA 98648
Mail to White Salmon
427-5611

Mental Health Boards

ADAMS

ADAMS COUNTY MH/MR BOARD
c/o Othello Rexall Drug Store
718 East Main
Othello, WA 99344

MID-COLUMBIA MENTAL HEALTH CENTER
1175 Gribble
Richland, WA 99352
943-9104

ADAMS COUNTY COUNSELING SERVICES
455 E. Hemlock Street
Box 338
Othello, WA. 99344
488-5611

ADAMS COUNTY COUNSELING
P.O. Box 302
Ritzville, WA 99169
659-1982 or 659-1111

ASOTIN-GARFIELD

ASOTIN-GARFIELD MH/DRUG TREATMENT BOARD
1326 - 3rd Street
Clarkston, WA 99403
758-2832

ASOTIN-GARFIELD MENTAL HEALTH CLINIC
1603 Dustan Loop
Clarkston, WA 99403
758-3341

BENTON-FRANKLIN

BENTON-FRANKLIN MH/MR BOARD
1327 North 16th Avenue
Pasco, WA 99301
545-3536 or 547-6285

MID-COLUMBIA MENTAL HEALTH CENTER
1175 Gribble
Richland, WA 99352
943-9104

CHELAN-DOUGLAS

CHELAN-DOUGLAS MH/MR BOARD
300 Main Street
E. Wenatchee, WA 98801
884-4986

CHELAN-DOUGLAS CO. COMMISSIONERS MH/MR BOARD
110 North Wenatchee Ave.
Wenatchee, WA 98801
662-7195

CHELAN-DOUGLAS CO. COMMISSIONERS MHC
110 North Wenatchee Ave.
Wenatchee, WA 98801
662-7105

CLALLAM

CLALLAM COUNTY MH BOARD
P.O. Box 660
Forks, WA 98331
374-6343

PENINSULA COUNSELING CENTER
603 E. 8th Street
Suite 4
Port Angeles, WA 98362
457-0432

PENINSULA COUNSELING CENTER*
603 E. 8th Street
Suite 4
Port Angeles, WA 98362
457-0432

MENTAL HEALTH OUTREACH*
Forks Community Hospital
RR3, Box 3575
Forks, WA 98331
374-6177 or 374-6271

CLARK

CLARK CO. SOCIAL SERVICES ADMINISTRATION BOARD
8409 N.E. Hazel Dell Ave
Vancouver, WA 98665
693-4791

CLARK COUNTY HUMAN RESOURCES
P.O. Box 5000
Vancouver, WA 98663
696-6433

ELAHAN*
1950 Fort Vancouver Way
Suite A
Vancouver, WA 98663
695-3416

COLUMBIA

COLUMBIA COUNTY MH BOARD
107 W. Washington Street
Dayton, WA 99328
382-4555

COLUMBIA COUNTY MHC*
206 South Fourth Street
Dayton, WA 99328
382-4198

COWLITZ-WAHKIAKIM

COWLITZ-WAHKIAKUM COUNTY MH/MR BOARD
3611 Pacific Way
Longview, WA 98632
425-2150 (Ext. 570)

HUMAN RESOURCES DEPT
County Administration Building
207 North 4th Avenue
Kelso, WA 98626
425-5880

LOWER COLUMBIA MH CENTER
1516 E. Kessler Boulevard
Longview, WA 98632

CRISIS CARE TEAM
1614 E. Kessler Boulev.
Longview, WA 98632
423-1530

FERRY

FERRY COUNTY MH BOARD
Box 5
Malo, WA 99150
779-2004

COMMUNITY SERVICES*
P.O. Box 443
Republic, WA 99166
775-3155

GRANT

GRANT COUNTY MH BOARD
22 "K" N.E.
Ephrata, WA 98823
754-4611 (Ext. 330)

GRANT COUNTY MH/DA/MR BOARD
P.O. Box 1216
Ephrata, WA 98823
754-2011 (Ext. 445)

GRANT COUNTY MH & FAMILY SERVICE CENTER*
P.O. Box 1057
Moses Lake, WA 98832
765-9239

GRAYS HARBOR-PACIFIC

GRAYS HARBOR-PACIFIC MH BOARD
Juvenile Department
County Courthouse
South Bend, WA 98586
875-5696

GRAYS HARBOR-PACIFIC MENTAL HEALTH
P.O. Box 621
Montesano, WA 98563
249-4257

GREYS HARBOR-PACIFIC COMMUNITY MH/FAMILY SERVICE CENTER*
215 Becker Building
Aberdeen, WA 98520
532-8629

ISLAND

ISLAND COUNTY MH ADMINISTRATIVE BOARD
5167 - 50th N.E.
Oak Harbor, WA 98277
675-0641

ISLAND COUNTY MH CLINIC
P.O. Box MM
Oak Harbor, WA 98277
678-5555

JEFFERSON

JEFFERSON CO. COMM. COUNSELING SERVICE*
802 Sheridan
P.O. Box 113
Port Townsend, WA 98368
385-0321

KING

KING COUNTY MH ADMINISTRATIVE BOARD
7714 South Mission Dr.
Seattle, WA 98178
772-0566

DIVISION OF HUMAN SERVICES
Room E-245
King County Courthouse
Third and James
Seattle, WA 98104
344-5210

DIVISION OF INVOLUNTARY TREATMENT SERVICES
E-224 King County Courthouse
Third and James
Seattle, WA 98104
344-7675

ASIAN COUNSELING & REFERRAL SERVICE*
655 South Jackson
Seattle, WA 98104
623-6756

CENTRAL AREA MH CENTER, INC.*
3601 South McClellan
Seattle, WA 98144
723-7770

COMMUNITY HOUSE*
1721 - 15th Avenue East
Seattle, WA 98122
322-2387

COMMUNITY PSYCHIATRIC CL*
1408 Northeast 45th
Seattle, WA 98105
634-3051

CONBELA*
945 Eliot Avenue West
Seattle, WA 98119
284-3901

CONSEJO*
9045 - 16th S.W.
Seattle, WA 98106
762-5665

CRISIS CLINIC*
1530 Eastlake East
Suite 301
Seattle, WA 98102
329-1882

EASTSIDE COMMUNITY MENTAL HEALTH CENTER
2253 140th N.E.
Bellevue, WA 98101
747-9000

HARBORVIEW COMMUNITY MH CENTER*
325 - 9th Avenue
Seattle, WA 98101

HIGHLINE-WEST SEATTLE MH CENTER*
10015 - 28th Avenue S.W.
P.O. Box 46503
Seattle, WA 98146
433-5750

MENTAL HEALTH NORTH*
10501 Meridian Ave. N.
Seattle, WA 98133
365-5550

SEATTLE CHILDREN'S HOME*
2142 10th West
Seattle, WA 98119
283-3300

SEATTLE COUNSELING SERVICE
1505 Broadway East
Seattle, WA 98112
329-8707/329-8737

MENTAL HEALTH SERVICES*
Seattle Hearing & Speech Center
1620 - 18th Avenue East
Seattle, WA 98122
323-5770

SEATTLE INDIAN HEALTH BOARD*
USPHS Hospital, Box 106
1131 14th Avenue S.
Seattle, WA 98144
324-9360

SEATTLE MENTAL HEALTH INSTITUTE*
1600 East Olive
Seattle, WA 98122
281-4308

VALLEY CITIES MH CENTER
2704 "I" Street N.E.
Auburn, WA 98002
854-0760 or 833-7444

YOUTH EASTSIDE SERVICES*
257 - 100th Avenue, N.E.
Bellevue, WA 98004
454-5502

KITSAP

DEPARTMENT OF COMMUNITY DEVELOPMENT
County Courthouse
614 Division
Port Orchard, WA 98366
876-7152

KITSAP RESOURCES
500 Union Street
Bremerton, WA 98310
373-5031

PENINSULA LODGE
146 North Marion
Bremerton, WA 98310
377-0059

KITSAP COUNTY MH/MR BOARD
Juvenile Court Service Center
1338 S.W. Old Clifton Rd
Port Orchard, WA 98366
692-4894

KITTITAS

KITTITAS COUNTY MMH/MR BD.
Route 3, Box 46
Ellensburg, WA 98926
963-2381

KITTITAS COUNTY MH/MR BD.
507 North Nanum Street
Ellensburg, WA 98926
925-1465

YOUTH SERVICES OF KITTITAS COUNTY
(309 N. Pearl St)
P.O. Box 523
Ellensburg, WA 98926
925-3847

CRISIS LINE
507 North Nanum Street
Ellensburg, WA 98926
925-4168

FAMILY SERVICE AND COUNSELING CENTER
103 West 5th Avenue
Suite 105
Ellensburg, WA 98926

KLICKITAT

KLICKITAT COUNTY MH ADVISORY BOARD
P.O. Box 126
White Salmon, WA 98672
493-1012

KLICKITAT COUNTY MH SERVICES*
(228 West Main)
Box 147
Goldendale, WA 98620
773-5801

LEWIS

LEWIS COUNTY MH AND ADMINISTRATIVE BOARD
995 State Route 507
Centralia, WA 98531
736-3639

OKANOGAN COUNTY FAMILY COUNSELING AND MENTAL HEALTH CENTER
Route 1, Box 26E
Omak, WA 98841
826-6191

LEWIS COUNTY ADMINISTRATIVE BOARD
County Courthouse
Chehalis, WA 98532
748-3121 (ext.149)

LEWIS COUNTY MH/MR PROGRAM
33 N.E. Boistfort
Chehalis, WA 98532
748-6696

LINCOLN

LINCOLN COUNTY MH BOARD
Sprague, WA 99032
725-3001

LINCOLN CO. COMM. SERV. PROJECT
(7th and Park)
Box 278
Davenport, WA 99122
725-3001

OKANOGAN

OKANOGAN COUNTY SOCIAL SERVICES BOARD
Route 1, Box 190
Twisp, WA 98858
422-6960

PEND OREILLE

PEND OREILLE MH/MR BOARD
American Lutheran Church
Newport, WA 99156

PIERCE

PIERCE COUNTY MH/DA BOARD
Suite A, Allenmore Medical Center
Tacoma, WA 98405
383-2413

PIERCE COUNTY SOCIAL SERVICES
Pierce County Health Building
3629 South "D" Street
Tacoma, WA 98408
593-4127

CHILD GUIDANCE CENTER*
3629 South "D" Street
Tacoma, WA 98408
593-4390

PEND OREILLE COMMUNITY MENTAL HEALTH CENTER*
Box 490
Newport, WA 99156
447-3175

COMPREHENSIVE MH CENTER OF TACOMA-PIERCE CO.*
P.O. Box 5007
Tacoma, WA 98405
597-8203/597-8206

GREATER LAKES MH CENTER*
9618 Gravelly Lake
Tacoma, WA 98499
584-8933

MENTAL HEALTH CLINIC*
Good Samaritan Hospital
407 - 14th Avenue S.E.
Puyallup, WA 98371
848-5571

OFFICE OF INVOLUNTARY COMMITMENT*
Puget Sound Hospital
36th and Pacific
Tacoma, WA 98048
473-2323

SAN JUAN

SAN JUAN CO. COMMUNITY SERVICE ADMIN. BOARD
Box 48
Eastsound, WA 98245
376-4347

SAN JUAN COMMUNITY SERVICES CENTER
P.O. Box 247
Friday Harbor, WA 98250
378-2669

SKAGIT

SKAGIT COUNTY MH/DA ADMINISTRATIVE BOARD
217 South 113th
Mount Vernon, WA 98233
424-7015

MENTAL HEALTH
1216 South 11th
Mount Vernon, WA 98273
336-9487

SKAGIT COUNSELING & PSYCHIATRIC SERVICES*
208 Kincaid
Mount Vernon, WA 98273

SKAMANIA

SKAMANIA COUNTY MH/MR BOARD*
Stevenson, WA 98648
427-5126

SKAMANIA COUNTY COUNSELING CENTER
P.O. Box Q
Stevenson, WA 98648
427-5636

SNOHOMISH

SNOHOMISH MH BOARD
Room 151
Old Mission Building
County Courthouse
Everett, WA 98201
652-7151 or 259-9401

SNOHOMISH COUNTY DRUG ABUSE COUNCIL*
2730 Pine Street
Everett, WA 98201
258-2649

COUNTERPOINT
2016 Pacific
Everett, WA 98201

SNOHOMISH CO. FAMILY COUNSELING SERVICE*
234 Olympic Boulevard
Everett, WA 98203
258-4521

SNOHOMISH COUNTY LUTHER CHILD CENTER*
P.O. Box 2097
Everett, WA 98203
258-4521

MENTAL HEALTH SERVICES, INC. OF SNOHOMISH CO.*
(4526 Federal Ave.)
P.O. Box 2887
Everett, WA 98203
252-1122

SPOKANE

SPOKANE COUNTY PUBLIC HEALTH CENTER
West 1101 College
Suite 370
Spokane, WA 99201
456-5722

COMMUNITY MENTAL HEALTH CENTER
South 107 Division Street
Spokane, WA 99202
838-4651

COMMUNITY SERVICES DEPT.
N. 721 Jefferson
Suite 403
Spokane, WA 99260
456-5722

STEVENS

STEVENS COUNTY MH/MR BOARD
219 South Elm
Colville, WA 99114
684-4213

STEVENS CO. COUNSELING SERVICE CENTER
603 S. Infirmary Rd.
Colville, WA 99114
684-4597

THURSTON-MASON

THURSTON-MASON MENTAL HEALTH BOARD
2223 East Bay Drive
Olympia, WA 98506
943-8128

COMMUNITY SERVICES
529 West 4th Street
Olympia, WA 98501
753-8071

COMMUNITY MENTAL HEALTH CENTER*
(2604 - 12th Court S.W)
P.O. Box 592
Olympia, WA 98507
943-4760

CRISIS CLINIC*
P.O. Box 2463
Olympia, WA 98507
754-3888

WALLA WALLA

WALLA WALLA COUNTY MH BOARD
415 Denny Building
Walla Walla, WA 99362
529-7030

DEPARTMENT OF HUMAN RESOURCES
Suite 102
County Courthouse
Walla, Walla, WA 99362
525-7940

WALLA WALLA MH CENTER*
216 South Palouse Street
Walla Walla, WA 99362
525-0241

WHATCOM

WHATCOM MH BOARD
510 Grand Avenue
Bellingham, WA 98225
733-5336 or 676-6768

WHATCOM COUNSELING & PSYCHIATRIC CLINIC*
1135 Mount Baker Highway
Bellingham, WA 98225
676-8455

BELLINGHAM-WHATCOM CO. DISTRICT HEALTH DEPT.
P.O. Box 935
Bellingham, WA 98225

SUN CRISIS CENTER*
P.O. Box 1222
Bellingham, WA 98225
734-7271

BLUE CANYON FOUNDATION
4000 Blue Canyon Road
Sedro Woolley, WA 98284
595-2222

SUN HALFWAY HOUSE*
1112 North Forest
Bellingham, WA 98225
734-9030

YWCA*
1026 North Forest Street
Bellingham, WA 98225
734-4820

CATHOLIC FAMILY & CHILDREN SERVICES
207 Kentucky
Bellingham, WA 98225
733-5800

WHITMAN

WHITMAN COUNTY MH BOARD
Box 295
Garfield, WA 99130

WHITMAN COUNTY MH CENTER*
N.E. 340 Maple
Pullman, WA 99163
564-5193

YAKIMA

YAKIMA COUNTY COMMUNITY SERVICES BOARD
310 N. 61st Avenue
Yakima, WA 98907
966-2459

CENTRAL WASH. COMP. MENTAL HEALTH
P.O. Box 959
Yakima, WA 98908
575-4295

YAKIMA COMMUNITY SVCS. ADMIN. BOARD
322 Washington Mutual
Yakima, WA 98901
575-4295

OFFICE OF HUMAN SERVICES
County Courthouse
Room 30
Yakima, WA 98901
575-4324

CENTRAL WASHINGTON COMPREHENSIVE MH*
P.O. Box 959
Yakima, WA 98907
575-4024

*MENTAL HEALTH AGENCIES

Developmental Disabilities Board

ADAMS CO. MH/MR
119 "I" St.
Lind, WA 99341

ASOTIN-GARFIELD COMMUNITY SERVICES
1603 Dustan Loop
Clarkston, WA 99403

BEN-FRANKLIN COMM. SER.
1175 Gribble Ave.
Richland, WA 99352

CLALLAM CO. MH/DD BOARD
603 E. 8th, Suite 4
Port Angeles, WA 98462

HUMAN RESOURCES DEPT.
P.O. Box 5000
Vancouver, WA 98663

COLUMBIA CO. SERVICES
206 S. 4th St.
Dayton, WA 99328

HUMAN RESOURCES COORDINATION/COMMUNITY DEVEL.
207 4th Ave. N.
Kelso, WA 98626

FERRY COUNTY COMM. SER.
P.O. Box 443
Republic, WA 99166

GRANT COUNTY MH/DRUG/MR BOARD
234 1st N.W.
P.O. Box 1216
Ephrata, WA 98823

GRAYS HARBOR-PACIFIC CO.
P.O. Box 621
Montesano, WA 98563

ISLAND CO. MR BOARD
P.O. Box 489
Oak Harbor, WA 98277

JEFFERSON COUNTY
MH/MR BOARD
892 Sheridan St.
Port Townsend, WA 98368

MR BOARD OF KING CO.
214 King Co. Admin. Bldg
Seattle, WA 98104

KING COUNTY COURTHOUSE
Room E-245
Seattle, WA 98104

KITSAP COUNTY COURTHOUSE
614 Division
Port Orchard, WA 98366

KITTITAS COUNTY MH/MR BOARD
507 Nanum
Ellensburg, WA 98926

KLICKITAT CO. MH SERV.
P.O. Box 147
Goldendale, WA 98620

LEWIS COUNTY MH/DD ADMINISTRATION BOARD
P.O. Box 278
Chehalis, WA 98532

LINCOLN CO. COMM. SER.
P.O. Box 278
Davenport, WA 99122

OKANAOGAN CO. DD
P.O. Box 647
Okanagan, WA 98840

PEND OREILLE COUNTY
COMMUNITY SERVICES
P.O. Box 490
Newport, WA 99156

PIERCE COUNTY
HEALTH BUILDING
3629 "D" Street
Tacoma, WA 98408

SAN JUAN CO. COMM. SER.
P.O. Box 247
Friday Harbor, WA 98250

SKAGIT CO. ADMIN. BLDG.
c/o Health Dept.
Mount Vernon, WA 98273

COUNSELING CTR.
P.O. Box Q
Stevenson, WA 98638

SNOHOMISH CO. DD BOARD
1st Floor Courthouse
Everett, WA 98201

BROADWAY CTR. BLDG.
Suite 403
North 721 Jefferson
Spokane, WA 99260

STEVENS CO. MH/MR BOARD
603 S. Infirmay Rd.
Colville, WA 99114

THURSTON/MASON SER. OFF.
529 W. 4th
Olympia, WA 98501

WALLA WALLA COUNTY
HUMAN RESOURCES
310 W. Poplar
Room 008
Walla Walla, WA 99362

WHATCOM CO. MR/DD BOARD
P.O. Box 1015
Bellingham, WA 98225

WHITMAN COUNTY DD BOARD
S.E. 1235 Professional Mall
Pullman, WA 99163

YAKIMA COUNTY DIV.
COMM. SERVICES
2011 S. 64th Ave.
Yakima, WA 98903

CHELAN/DOUGLAS MH/MR BOARD
110 N. Wenatchee Ave.
Wenatchee, WA 98801

Developmental Centers

ADAMS

ADAMS COUNTY DEVELOPMENTAL CENTER
North 119 "I" St.
Lind, WA 99341
677-3260

ASOTIN-GARFIELD

ASOTIN-GARFIELD DEVELOPMENTAL DISABILITIES PROGRAM
1603 Dustin Loop
Clarkston, WA 99403
758-3341

BENTON-FRANKLIN

BENTON-FRANKLIN DEVELOPMENTAL CENTER
767 William Blvd.
Richland, WA 99352
946-4146

UNITED CEREBRAL PALSY OF BENTON-FRANKLIN COUNTIES
741 South Dayton
Kennewick, WA 99336
586-4154

CHELAN-DOUGLAS

NORTH CENTRAL WASHINGTON SUPERVISED SKILLS
327 East Penny Road
Wenatchee, WA 98801
663-0743

UNITED CEREBRAL PALSY ASSOCIATION OF WENATCHEE VALLEY (Adult)
P. O. Box 1
Wenatchee, WA 98801
884-3924

CLALLAM

CLALLAM COUNTY DAY TRAINING CENTER
Sixth and Laurel Streets
Port Angeles, WA 98362
457-8355

DIVERSIFIED INDUSTRIES, INC.
2602 West 18th
Port Angeles, WA 98362
452-9789

CLARK

CLARK CARE AND DEVELOPMENTAL CENTER, INC.
P. O. Box 2338
Vancouver, WA 98664
696-0667

SHO-CRAFT
3209 N. W. Lower River Road
Vancouver, WA 98660
696-4638

VALLEY ACTIVITIES CENTER
P. O. Box 61501
Vancouver, WA 98666
696-1368

COWLITZ-WAHKIAKUM

ADULT DEVELOPMENTAL CENTER
839 - 15th
Longview, WA 98632
423-2640

PROGRESS CENTER, INC.
2742 Harding Street
Longview, WA 98362
425-9810

GRANT

GRANT COUNTY TRAINING CENTER
Grant County Airport
Building 2114
Moses Lake, WA 98837
762-5322

GRAYS HARBOR

TIMBERLAND OPPORTUNITIES
400 West Curtis
Aberdeen, WA 98520
533-5823

BAYSHORE ENTERPRISES
%Jefferson County
Multiservices Bldg.
(802 Seridan)
Box 113
Port Townsend, WA 98368
385-3328

KING

CHILDREN'S CLINIC
AND PRESCHOOL
1750 Boyer Ave. East
Seattle, WA 98102
325-8477

COMMUNITY ENTERPRISES
OF ISSAQUAH
40 - Fifth Ave. N.E.
Issaquah, WA 98027

CRESTVIEW CENTER
16200 - 42nd Ave. S.
Seattle, WA 98188
243-4263

CUSTOM INDUSTRIES
10432 N.E. 8th Street
Bellevue, WA 98004
455-4611

EXPERIMENTAL EDUCATION
UNIT
% University of Wash-
ington
WJ-10
Seattle, WA 98195
543-4011

INDUSTRIAL SKILLS
P. O. Box 3369
Federal Way, WA 98003
852-3650

KING COUNTY ARC
2230 - 8th
Seattle, WA 98101
622-9292

LIGHTHOUSE FOR THE BLIND
(2501 South Plum)
P. O. Box C-14119
Seattle, WA 98114
322-4200

MERRYWOOD SCHOOL
P. O. Box 975
Bellevue, WA 98009
454-6138

NORTHWEST CENTER FOR
THE RETARDED
1600 West Armory Way
Seattle, WA 98119
282-3547

RANDOLPH CARTER
INDUSTRIAL WORKSHOP
100 - 23rd Avenue S.
Seattle, WA 98144
329-8500

SNO-VALLEY SCHOOL FOR
SPECIAL NEEDS
P. O. Box 300
Snoqualmie, WA 98065
888-2777

UNITED CEREBRAL PALSY OF
KING/SNOHOMISH COUNTIES
4409 Interlake Ave. N.
Seattle, WA 98103
632-2827

VALLEY BIRTH-TO-FIVE
2450 Star Lake Road
Federal Way, WA 98003
839-8150 (Ext. 214)

W.I.S.E.R. INSTITUTE
P. O. Box 578
Bothell, WA 98011
364-5545

WONDERLAND DEVELOP-
MENTAL CENTER
N.W. 158th and 20th N.E.
Seattle, WA 98155
364-3238

KITSAP

HOLLY RIDGE CENTER, INC.
3423 - 6th Street
Bremerton, WA 98310
373-2536

LAKE OAK PATCH
UNLIMITED, INC.
P. O. Box 575
Bremerton, WA 98310
275-2741

OLYMPIC PENINSULA
ENTERPRISES
5700 Highway No. 3 South
Bremerton, WA 98310
377-3966

PENINSULA LODGE
Drawer PP Wycoff Station
Bremerton, WA 98310
377-0059

KITTITAS

KITTITAS COUNTY DEVELOP-
MENTAL CENTER, INC.
(ELMVIEW CENTER)
Route 4, Box 163-E
Ellensburg, WA 98926
925-6124

LEWIS

LEWIS COUNTY
PREVOCATIONAL CENTER
P. O. Box 667
Chehalis, WA 98531
748-9131 (Ext. 265)

OKANOGAN

OKANOGAN COUNTY
DEVELOPMENTAL CENTER
P. O. Box 647
Okanogan, WA 98840
422-1222

PACIFIC

PENINSULA ACTIVITY CENT.
P. O. Box 201
Ilwaco, WA 98624
777-8377

PIERCE

CHILD DEVELOPMENT CENTER
432 Wood Avenue
Sumner, WA 98390
863-8800

H.E.L.P. CENTERS
602 North Orchard
Tacoma, WA 98406
759-3656

LAKEWOOD HOPE CENTER
5219 - 111th S. W.
Tacoma, WA 98499

MARY BRIDGE CHILD
DEVELOPMENT AND LEARNING
CENTER
316 North "L" Street
Tacoma, WA 98403
383-4036

PACIFIC CARE CENTER
1231 South 76th
Tacoma, WA 98408
475-5717

TACOMA GOODWILL
714 South 27th
Tacoma, WA 98409
272-5166

UNITED CEREBRAL PALSY OF
PIERCE COUNTY, INC.
2366 Tacoma Avenue
Tacoma, WA 98402
627-1716

VADIS
1516 Fryar Avenue
Sumner, WA 98390
863-5173

VALLEY SCHOOL FOR
SPECIAL EDUCATION
P. O. Box 164
Puyallup, WA 98371
848-4040

SKAGIT

GET THERE
SOCIAL SERVICES
P. O. Box 402
Mount Vernon, WA 98273
336-3580

SKAGIT PRESCHOOL ASSOCIA-
TION FOR THE REHABILITA-
TION OF CHILDREN (SPARC)
P. O. Box 131
Burlington, WA 98233
757-8831
Correspondence to:
1490 Allen West Road
Bow, WA 98232

SNOHOMISH

HEALEY DEVELOPMENTAL
CENTER
(VOLUNTEERS OF AMERICA)
2801 Lombard
Everett, WA 98201
259-3191

LITTLE RED SCHOOLHOUSE
P. O. Box 992
Lynnwood, WA 98036
743-0616

RESOURCE VILLAGE
503 - 316th Street N.W.
Stanwood, WA 98292
778-0168

SHERWOOD
LEARNING CENTER
410 - 91st Avenue N.E.
Everett, WA 98205
334-4071

SNOHOMISH COUNTY
CENTER FOR THE
HANDICAPPED
1314 - 26th Street
Everett, WA 98201
252-9207

WORK OPPORTUNITIES, INC.
6517 - 202nd Street S.W.
Lynnwood, WA 98036
778-5054

SPOKANE

FIELD SCHOOL
North 1216 Superior
Spokane, WA 99202
456-5019

NEW HOPE TRAINING
CENTER FOR THE
HANDICAPPED, INC.
North 417 Willow Road
Spokane, WA 99206
926-4441

PREVOCATIONAL
TRAINING CENTER
North 2526 Division
Spokane, WA 99207
326-6760

SPOKANE GUILDS SCHOOL
South 412 Bernard Street
Spokane, WA 99204
624-2265

STEVENS

JESSIE WEBB
VOCATIONAL CENTER
P. O. Box 207
Colville, WA 99114
684-5228

THURSTON-MASON

MORNINGSIDE INDUSTRIES
P. O. Box 924
Olympia, WA 98507
943-0512

UNITED CITIZENS
BETTERMENT ORGANIZATION
(UCBO)
P. O. Box 446
Yelm, WA 98597
548-7000

EXCEPTIONAL
FORESTERS, INC.
P. O. Box 86
Shelton, WA 98584
426-1550

WALLA WALLA

LILLIE RICE CENTER, INC.
1627 Evergreen Street
Walla Walla, WA 99362
525-3532

WHATCOM

FERNDALE VOCATIONAL
SKILLS CENTER
P. O. Box 1103
Ferndale, WA 98248
676-2170 (Ext. 59)

WHATCOM ASSOCIATION OF
TRAINING CENTER, INC.
(WATCI)
P. O. Box 104
Bellingham, WA 98225
734-9240

WORKSHOP FOR THE
HANDICAPPED
803 East North Street
Bellingham, WA 98225
734-5353

WHITMAN

WHITMAN COUNTY EPTON
SOCIETY PRESCHOOL FOR
DEVELOPMENTALLY DELAYED
CHILDREN and WHITMAN
COUNTY EPTON SOCIETY
ADULT ACTIVITY CENTER
N. W. 1210 Nye
Pullman, WA 99163
332-7653

YAKIMA

HOPE ENTERPRISES
501 Highway 12
Sunnyside, WA 98944
837-7993

SPECIAL PROJECTS FOR
THE HANDICAPPED
P. O. Box 9543
Yakima, WA 98909
453-8929 or 8920

Group Homes

ALPHA GROUP HOME
(Adults)
3018 - 14th West
Seattle, WA 98119
284-9130

ANGELINE HOUSE
(Adults)
348 - 18th East
Seattle, WA 98112
325-8266

BARGER GROUP HOME
(Children)
608 South 4th Street
Yakima, WA 98901
457-6550

CAMELOT CENTER FOR
EXCEPTIONAL CHILDREN
9201 N. W. Second
Seattle, WA 98117
783-2373

CANTERBURY HOUSE
(Adults)
615 Lawrence
Mount Vernon, WA 98273
336-3580

COLONIAL GROUP HOME
(Adults)
1412 West Chestnut
Yakima, WA 98905
452-4245

COTTONWOOD LODGE
(Adults)
1524 Third Avenue
Longview, WA 98632
636-5090

CROWN HILL GROUP HOME
(Adults)
9523 - 15th N. W.
Seattle, WA 98117
782-4293

DELPHI HOUSE (Adults)
4418 Delphi Road S.W.
Olympia, WA 98502
866-8390

ELMVIEW GROUP HOME
(Adults)
220 East Helena Street
Ellensburg, WA 98926
925-5008

EPTON HOUSE (Children)
S.E. 729 Ridge View Ct.
Pullman, WA 99163
332-7653

FERNDALE GROUP HOME
(Adults)
2543 Mountain View Rd.
Ferndale, WA 98248
384-5006

FRANKLIN HEIGHTS LODGE
(Adults)
4809 Franklin Street
Vancouver, WA 98663
693-7707

GREY POPLARS GROUP
HOME (Adults)
P. O. Box 5
Harrah, WA 98933
848-2174

HALLER LAKE HOMES
(Adults)
1707 North 125th
Seattle, WA 98133
362-0180

HAMPTON HEIGHTS
(Adults)
2605 Hampton Place
Bellingham, WA 98225
734-3334

HARMONY HOUSE
(Children)
E. 2709 - 55th
Spokane, WA 99203
448-2383

HARRAH GROUP HOMES
(Adults)
P. O. Box 5
Harrah, WA 98933
848-2174

HEARTHSIDE HOUSE
(Children)
Route 1, Box 309
Soap Lake, WA 98851
246-1320

HELENA CHILDREN'S HOME
(Children and Adults)
(12th and Hendricks
Streets)
P. O. Box 767
Port Townsend, WA 98368
385-2884

HERITAGE HOUSE
(Adults and Children)
503 South 3rd
Kent, WA 98031
854-5183

HILLSIDE HOUSE
(Children)
2415 - #1 Canyon Road
Wenatchee, WA 98801
662-5412

HOLLY HOUSE (Adults)
1825 South 310th
Federal Way, WA 98003
941-0916

HOLLY RANCH (Adults)
607 East Smith Road
Bellingham, WA 98225
734-3334

ILLAHEE GROUP HOME
(Children and Adults)
3333 Hollywood Avenue
Bellingham, WA 98225
734-3740

INGLEWOOD GROUP HOME
(Children and Adults)
7845 N. E. 195th
Bothell, WA 98011
486-8333

INTERLAKE GROUP HOME
(Adults)
8836 Interlake North
Seattle, WA 98103
525-0515

JUNIPER RIDGE GROUP HOME
664 South Juniper
Moses Lake, WA 98837
765-1161

KAMIAKIN GROUP HOME
(Adults)
P. O. Box 5
Harrah, WA 98933
848-2174

HAZEL J. KELLER I
GROUP HOME (Children)
16041 Wallingford North
Seattle, WA 98133
546-3225

HAZEL J. KELLER II
GROUP HOME (Children
and Adults)
12718 - 15th N. E.
Seattle, WA 98125
362-7480

LAKE HILL GROUP HOME
(Adults)
15007 Highway 99
Lynnwood, WA 98036
743-6121

LAKESIDE GROUP HOME
(Children)
11723 Fifth N. E.
Seattle, WA 98125
363-1022

LAURIDSEN EAST (Adults)
430 East Lauridsen Blvd.
Port Angeles, WA 98362
457-5576

LAURIDSEN WEST (Adults)
430 East Lauridsen Blvd.
Port Angeles, WA 98362
457-5576

MARIA CHILDREN'S HOME
(Children and Adults)
(1042 Corona)
P.O. Box 767
Port Townsend, WA 98368
385-2567

MIDWAY HOUSE GROUP HOME
(Children)
1803 South 246th Place
Kent, WA 98031
824-2579

MISSION VISTA (Adults)
Third and Colorado
291 Third Street N. E.
E. Wenatchee, WA 98801
884-4512

MOUNTAIN VIEW GROUP HOME
(Children)
2545 Mountain View Road
Ferndale, WA 98248
384-5006

OLYMPIC VIEW GROUP HOME
(Children)
1417 South 27th
Renton, WA 98055
226-6423

OUTLOOK INN (Adults)
138 West 2nd Street
Port Angeles, WA 98362
452-9663

PARKVIEW HOME FOR
EXCEPTIONAL CHILDREN I
1114 - 15th Avenue East
Seattle, WA 98102
322-1510

PARKVIEW HOME FOR
EXCEPTIONAL CHILDREN II
1918 - 33rd South
Seattle, WA 98144
324-4113

PARKVIEW HOME FOR
EXCEPTIONAL CHILDREN III
1918 - 33rd South
Seattle, WA 98144
324-4113

PHOENIX HOUSE (Children)
2514 South 92nd
Tacoma, WA 98409
584-6198

PINEVIEW GROUP HOME
(Adults)
2209 West 4th Avenue
Spokane, WA 99204
624-2730

GROVER F. POWERS
GROUP HOME (Children)
(formerly Kaskidian)
Route 5, Box 1020
Ellensburg, WA 98926
925-5092

RESIDENCE EAST (Adults)
600 - 124th Avenue N.E.
Bellevue, WA 98006
455-4071

STONE CREEK LODGE
(Adults)
225 Lodge Drive
Walla Walla, WA 99362
525-0140

TWIN FIRS GROUP HOME,
Inc. (Adults)
3731 Auburn Way South
Auburn, WA 98002
939-1020

VENTURE MANOR GROUP HOME
(Adults)
2025 West 4th Avenue
Spokane, WA 99204
747-2771

WEDGEWOOD GROUP HOME
(Adults)
7431 - 26th Avenue N.E.
Seattle, WA 98115
522-2777

WILLIAMS GROUP HOME
(Adults)
761 Williams Boulevard
Richland, WA 99352
943-1456

W.I.S.E.R. ACRES
(Children and Adults)
19205 Ross Road
Bothell, WA 98011
527-1550

DSHS Case Services

REGION 1

507 North Howard
Suite 206
Spokane, WA 99201
456-2893

WENATCHEE OUTSTATION
6 First Street, Room 4
Exchange Building
Wenatchee, WA 98801
662-1685

COLVILLE OUTSTATION
Route 3, 1100 South Main
Colville, WA 99114
684-5261

EPHRATA OUTSTATION
121 - 1st S. W.
Ephrata, WA 98823
754-3417

OMAK OUTSTATION
Route 1, Box 24-E
Omak, WA 98841
826-0082

PULLMAN OUTSTATION
126 South Grand Avenue
Pullman, WA 99163
456-3159

REGION 2

P. O. Box 9788
Yakima, WA 98909
575-2330

CLARKSTON OUTSTATION
720 - 6th Street
Clarkston, WA 99403
758-5537

ELLENSBURG OUTSTATION
P. O. Box 366
Ellensburg, WA 98926
925-9834

TRI-CITIES OUTSTATION
(805 Williams Avenue)
P. O. Box 495
Richland, WA 99352
946-6196

WALLA WALLA OUTSTATION
P. O. Box 517
Walla Walla, WA 99362
527-4270

REGION 3

2925 Rockefeller
Everett, WA 98201
259-5744

MT. VERNON OUTSTATION
2021 College Way
Room 208
Mount Vernon, WA 98273
424-4130

BELLINGHAM OUTSTATION
(222 Unity)
P. O. Box 639
Bellingham, WA 98225
676-2129

REGION 4

1700 E. Cherry Street
Seattle, WA 98122
464-5488

BELLEVUE OUTSTATION
15027 Main Street
Bellevue, WA 98007
455-7122

KENT OUTSTATION
Meeker's Landing
1317 West Meeker
Kent, WA 98031
872-6490

REGION 5

1305 Tacoma Avenue South
Room 306
Tacoma, WA 98402
593-2812

BREMERTON OUTSTATION
% Olympic Center
(3423 - 6th Street)
P. O. Box 4099
Wycoff Station
Bremerton, WA 98310
478-4703

REGION 6

344 Clevelend, Suite C
Tumwater, WA 98502
753-4673

ABERDEEN OUTSTATION
P. O. Box 189
Aberdeen, WA 98520
532-0962 (Ext. 200)

PORT ANGELES OUTSTATION
1215 E. 1st Street
Suite E
Port Angeles, WA 98362
452-3327

VANCOUVER OUTSTATION
P. O. Box 1998
Vancouver, WA 98662
696-6350

LONGVIEW OUTSTATION
1427 - 15th Avenue
Longview, WA 98632
577-2068

Toll Free Hotline
Number: 1-800-562-6028

Division of Vocational Rehabilitation

REGION 1

SPOKANE REGIONAL OFFICE
510 Hutton Building
Spokane, WA 99204
456-4420

REGION 2

YAKIMA REGIONAL OFFICE
(Yakima Valley Mall)
P. O. Box 9788
Yakima, WA 98909
575-2159

REGION 3

EVERETT REGIONAL OFFICE
302 Central Building
Everett. WA 98201
259-5769

REGION 4

SEATTLE REGIONAL OFFICE
Cherry Hill Building
1700 East Cherry
Seattle, WA 98122
484-7790

REGION 5

TACOMA REGIONAL OFFICE
302 - 1305 Tacoma Ave. S.
Tacoma, WA 98402
593-2353

REGION 6

OLYMPIA REGIONAL OFFICE
(5000 Capitol Boulevard)
P. O. Box 2487
Olympia, WA 98504
753-2762

FIELD OFFICES

ABERDEEN OFFICE
(Region 6)
405 West Wishkah
Aberdeen, WA 98520
533-9274

AUBURN OFFICE
(Region 4)
800 - 4th Street N. E.
Auburn, WA 98002
833-6990

BELLEVUE OFFICE
(Region 4)
15027 Main Street
Bellevue, WA 98007
455-7144

BELLINGHAM OFFICE
(Region 3)
222 Unity Street
Bellingham, WA 98225
676-2125

BOTHELL OFFICE
(Region 4)
18315 N.E. Bothell Way
Bothell, WA 98011
485-0286

BREMERTON OFFICE
(Region 5)

(217 Olympic Center
Building)
3423 - 6th Street
Bremerton, WA 98310
478-4982

East High School
1300 - 11th Street
Bremerton, WA 98310
478-5077

BURIEN OFFICE
(Region 4)
320 - 4 Sharon Avenue
Burlington, WA 98233
478-5077

CHEHALIS OFFICE
(Region 6)
(2025 N. E. Kresky Rd.,
Chehalis)
P. O. Box 662
Centralia, WA 98531
748-4429

COLVILLE OFFICE
(Region 1)
Rt. 3
1110 South Main
Colville, WA 99114
684-5216

EDMONDS OFFICE
(Region 3)
8500 - 200th Southwest
Edmonds, WA 98020
774-2664

FEDERAL WAY OFFICE
(Region 4)
31455 - 28th Avenue S.
Federal Way, WA 98003
941-0100

LONGVIEW OFFICE
(Region 6)
1122 - 14th Avenue
Longview, WA 98632
577-2226

MAPLE VALLEY OFFICE
(Region 4)
Cedar Hill Alcoholic
Treatment Center
15825 - 228th Ave. S.E.
Maple Valley, WA 98038
228-5690

MOSES LAKE OFFICE
(Region 1)
Vista Village Shopping
Center
Moses Lake, WA 98837
765-1321

MOUNTLAKE TERRACE OFFICE
21309 - 44th Avenue West
Mountlake Terrace, WA
98043
775-5555

PASCO OFFICE
(Region 2)
(800 West Court)
P. O. Box 931
Pasco, WA 99301
545-2220

PORT ANGELES OFFICE
(Region 6)
403 East 8th Street
Port Angeles, WA 98362
457-8558

PULLMAN OFFICE
(Region 1)
(461 Holland Library, WSU)
P. O. Box C
College Station
Pullman, WA 99163
335-7526

PUYALLUP OFFICE
(Region 5)
1004 East Main
Puyallup, WA 98371
593-8661

SEATTLE OFFICES
(Region 4)

1701 Broadway
Seattle, WA 98122
464-6300

909 Smith Tower
Correctional Rehabilitation Program
464-6577

University District Building
1107 Northeast 45th
Seattle, WA 98105
464-7976

619 - 2nd Avenue
Room 202
Seattle, WA 98104
464-6917

907 Northwest BallardWay
Seattle, WA 98L07
545-7730

1023 Smith Tower
Seattle, WA 98104
464-6304

700 Broadway
Kidney Program
464-7175

1606 Northeast 150th
Seattle, WA 98155
545-6679

SHELTON OFFICE
(Region 6)
(110 West K Street)
P. O. Box 458
Shelton, WA 98584
426-2679

SPOKANE OFFICES
(Region 1)
North 1810 Greene Street
Spokane, WA 99207
535-0641

3102 East Trent
Spokane, WA 99202
456-4424

TACOMA OFFICES
(Region 5)
Central School
(601 South 8th)
P. O. Box 1357
Tacoma, WA 98401
539-6676

316 - 1305 Tacoma Ave.S.
Tacoma, WA 98402
593-5076

VANCOUVER OFFICES
(Region 6)
(613 W. Evergreen Blvd.)
P. O. Box 88
Vancouver, WA 98661
694-0751

Hudson Bay High School
1206 East Reserve Street
Vancouver, WA 98661
694-0751

WALLA WALLA OFFICE
(Region 2)
206 West Poplar
Walla Walla, WA 99362
526-4325

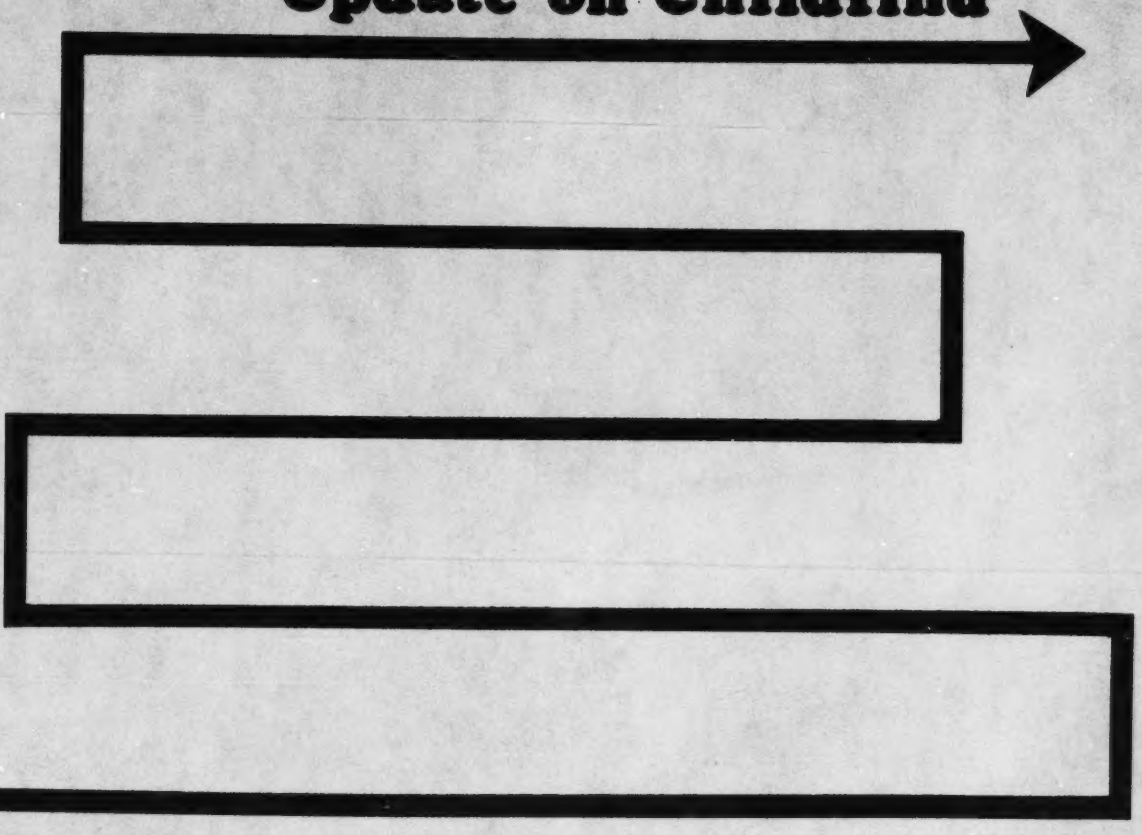
WENATCHEE OFFICE
(Region 1)
South 3 Wenatchee Ave.
(Room 210)
Wenatchee, WA 98801
662-5161

YAKIMA OFFICES
1211 South 7th Street
Yakima, WA 98901
575-2630

212 South 6th
Yakima, WA 98902
575-2340

Yakima Valley Mall
Yakima, WA 98909
575-2143

Update on Childfind



Frank B. Brouillet, Superintendent
Judy Schrag, Assistant Superintendent,
Division of Special Services

INTRODUCTION

This document was developed to serve as an addendum to the child find manual distributed during the Fall of 1979. Included are the results of a childfind study that has been conducted by the Office of Superintendent of Public Instruction and recommended procedures and practices for childfind. The following individuals contributed their time and expertise to this project:

Dr. Eugene Edgar	Dept. of Special Education University of Washington
Dr. Linda Espinosa	Early Childhood Coordinator Office of Superintendent of Public Instruction
Marsha Shearer	Project Search Director ESD #121

Update on Child Find
September, 1980

There have been a number of effective child find activities that have been developed or refined during this past year. This update will provide a brief report on these activities as well as guidelines for LEA personnel on how to implement these activities. As with all child find activities LEA Personnel have to decide which activities best suit their district's needs. Probably no one district will choose to use all these procedures.

Data Analysis Procedures

During the past year a child find data analysis procedure has been developed by personnel from the University of Washington and the Division of Special Services of OSPI. Briefly, the identified handicapped population of the school district is recorded by handicapping condition and age (see chart I). The total LEA school age population by grade level is recorded. Chart I has the target percentage per category that sums to the 12% figures used by the Office of Special Education (formerly Bureau of Education for the Handicapped). Estimate the preschool total LEA population by using grade 1 figures (i.e., if there are 832 children in grade 1, estimate 800 four year olds). By summing across age (grade) levels you will be able to determine how close you are to serving the estimated percentage by grade (and handicapping condition). This data should assist you in determining at what age level to put your child find efforts. By summing by category you should be able to esatimate if you need to concentrate your child find efforts on a specific type of disability. If your district contracts children out or in (i.e., hearing impaired go to a co-op program outside of the district or another district sends multiply handicapped children to your district) add or subtract these numbers as indicated. This rough data analysis should help a district analyze the effectiveness of their current child find procedures and determine where to concentrate their efforts.

From an analysis of eight (8) Washington state districts, three (3) Idaho districts, and one (1) Texas district we have been able to identify several trends which should provide additional assistance to districts in their data analysis. We would like to briefly describe some of these trends so as to assist districts in determing what their data indicate. We will discuss the issues of age related disabilities, cross category contamination, communication delay, and some preliminary estimates of actual percentages of handicapped children.

Age. Many of the handicapping conditions are closely associated with age. For example, there are a number of handicapping conditions that DO NOT vary by age. These are: Orthopedic Handicaps, Health Impaired, Moderate Retardation, Severe/Profound Retardation, Multi handicapped, Neurologically Handicapped (Cerebral Palsy), Hearing Impairments, Partially Sighted, Blind. These conditions, while susceptible to educational interventions are seldom, if ever, ameloriated. Therefore a district should expect a stable percentage of these types of children across all age levels.

On the other hand there are a number of handicapping conditions that are directly age related: Communication Disorders, Learning Disability, Mild Retardation, and to a degree Behavior Disorders. Communication disorders are most

common in grades one through four. There may be a considerable number at the preschool and kindergrten level but by grade six there should be very few communication disordered children.

Due to our definitions, learning disabilities are difficult to identify prior to grades 2 or 3. There also appears to be a consistent drop off of the number of LD children after grade nine. This could be due to a number of factors; our techniques work and the children return to regular classes and are no longer identified as handicapped; chemical changes of the body during puberty allow the LD child to learn in adolescence; we have few secondary programs and therefore the LD student is thrown back into the mainstream without help; the adolescent LD child is classified something else (BD?); the LD student drops out of school. For whatever reasons, there is a dramatic decrease in the percentage of learning disabled children at the secondary level.

Cross Category Contamination: One noteworthy characteristic of the data we analyzed was the wide variance in the percentage of various handicapping conditions. Some districts reported up to 2.2 percent of their children as Behavior Disordered while other districts less than .5%. When analyzed by age (i.e., comparison of all districts by handicapping conditions and age level) there were discrepancies of up to four percentage points between districts. We found these discrepancies across districts, ages, and handicapping conditions. There appeared to be no pattern to these discrepancies until we collapsed categories. The fact that there is flexibility in our definitions of handicapping conditions allows individual districts to clasify children into one or another category. We guess that this is done for various reasons, e.g., biases of the tester, existence of programs, better funding for one category or another, etc. Regardless, our categories are not independent of one another. This is especially true when across state comparisons are made. Therefore, we collapsed all handicapping conditions into four categories; Mild (LD, BD, Mild MR); Severe (Ortho, Health, Mod. MR, Sev. MR, Multi Handi, Neuro); Sensory (Hearing Impaired, Partially Sighted, Blind); Communication Disorders. Collapsing these data across all districts and plotting the data by age, resulted in far less variance between school districts. Thus, any individual district should carefully examine their classification policies and perhaps even collapse categories as indicated above in order to determine if they are serving all possible handicapped children.

Communication Disorders. The single greatest variance between school districts and in fact between states, is the percentage of children served identified as communication disordered. These children have no other handicapping condition other than their communcation disorder. Our data (from 1979-80) indicates that districts in Washington are not serving large numbers of communication disordered children. (1.8 percent is the highest in Washington, whereas the Idaho districts served 2.6-2.8 percent). Two districts in Washington were serving less than .59%. This issue has been discussed at length in a recent doctoral dissertation by Charlene Behrns at the University of Washington. The final analysis seems to be that districts use their Communication Disorder Specialists to serve children with other handicapping conditions and not those children who only have communication disorders.

Best Guess Percentges. Given all the data we have analyzed, the following is our best guess for percentages of handicapped children likely to be served. These figures may vary somewhat within individual districts. Some districts may have more children due to families moving to those districts that have outstanding programs. Districts that serve a high percentage of disadvantaged populations may also have higher percentages. Rural district may have lower percentages due to families moving to urban areas and the likelihood of not having any of the low incidence conditions due to small population size. Each district will have to determine if any of these special conditions apply to them.

Severe Conditions (Orthopedically Handicapped, Health Impaired, Moderate Reatrdation, Severe/Profound Retardation, Multiply Handicapped, Neurologically Impaired) - .6 - 1.0% across all age categories.

Sensory Conditions (Partially Sighted, Blind, Hearing Impaired) .1% across all age categories.

Note urban districts have a higher percentage of sensory impaired children, perhaps as high as .8%. This is probably due to families moving to urban areas in search of services. Conversely this category is most likely to be lower in rural areas.

Communication Disorders. A total of 2 to 2.5% of the total school age population is not an unrealistic number. Remember, these children are predominantly found in grades 1-4 and therefore at those age levels the percentages may be as high as 4-5%.

Mild (BD, LD. Mild MR) This is the most variable group and is also age specific. A reasonable percentage is 5% for the total school age population. Again, the elementary grades will have the highest percentage, sometimes as high as 6-7%.

Summing these percentages, our best guess for a typical district is 7.7-8.6% of the total school age population can expect to be classified as handicapped at any given time.

What We Know About Locating Unserved Children

The following information is summarized from four years of careful study by the Dallas Independent School District of how best to locate handcapped children. The Dallas district engaged in systematic child find activities from 1975 through 1979 and carefully evaluated the effects of these efforts. What is especially notable is that these activities began in 1975, that a wide range of activities were tried, and that detailed data were maintained so that the most effective procedures could be retained and less effective procedures eliminated. These data have been nicely summarized in a final report (Gilham-Carpenter, Turner, & Macy, 1978).

The Dallas procedures included: print media campaigns, TV-radio campaigns, use of a 24 hour hotline, formal agency contacts, regular educator awareness, and house to house canvasing. The Dallas system serves some 130,000 school aged

children. Preschool education for handicapped children ages 3-5 is mandated and there is a federally funded birth to 3 handicapped program. There has been a recent merger of mental health-mental retardation programs into the public school. This is roughly analogous to our relationship with the Division of Developmental Disabilities (DD Centers).

Print Media Campaigns. There were three basic techniques explored which used traditional print media; newspaper articles, posters, and bumper stickers. The newspaper articles and bumper stickers resulted in very few referrals. On the other hand, the posters resulted in some 10% of the total referrals, a very substantial number. Of special note was the need to use key words on the posters. For example, the word handicapped is translated to physical handicap for a large number of people. School problems, trouble leaning, and disability are words that add breadth to the media effort. Print media should convey the message that all types of handicapping conditions are included. Also, the posters must include a method of getting in touch with appropriate people if a problem is suspected (hotline number).

TV-Radio Campaigns. Spot advertisements in TV and radio did not produce a substantial number of referrals.

Twenty-four Hour Hotline. The hotline, staffed during the day and using a recording at night proved indeispensible. This allowed referrals from all sources to be logged and followed up.

Formal Agency Contacts. Personal contacts were made with all agencies that typically came in contact with handicapped children and their families. These included public health agencies, welfare agencies, diagnostic centers, developmental disability centers. Each personal contact also included a printed brochure on types of handicapping conditions, services offered by the schools, and the hotline telephone number. Data indicate that frequent telephone contacts (quarterly) greatly increased the referral rate of those agencies. This contact serves as a reminder and also alerts new staff. Staff turnover at these agencies tends to be high and repeated contact is important for this reason.

Regular Educator Awareness. All public school staff received written materials on the types of children served by special education, the services offered by special education, and how to make referrals. In Dallas the regular school staff were encouraged to use the hotline number to make referrals.

House to House Canvas. Two separate sections of the Dallas district were targeted for a house to house canvas. Each house in the target area was visited. If personal contact was not made a brochure was left at the door. The personal message and written materials reviewed the types of children served by special education. Very few children were located using this method.

Summary of Dallas Child Find Activities

Year	Total Number of Referrals
1975-76	106
1976-77	226
1977-78	254
1978-79	187

Seventy-five percent (75%) were at or below the elementary level (50% ages 3-5).

1978-79	Breakdown
0-2	46
3-5	105
6-12	26
13-18	10
+ 19	0

Where the referrals came from

Agencies	45%
School Personnel	26%
Print Media	10%

From these experiences, the following recommendations have been made by the Dallas personnel.

1. organize an interagency task force to oversee child find efforts
2. define referral procedures
3. develop a protocal for handling telephone contacts
4. make regular visits to human service agencies
5. offer a 24 hour telephone service
6. use print media (posters) in community locations
7. have screening/assessment/placement procedures in order
8. keep time lag from referral to placement as short as possible

Screening Activities in the State of Washington

There has been a number of formal screening activities in Washington State this year. Project FIND, coordinated by Marsha Shearer at ESD 121 has resulted in well over 1000 children being screened. Predominately these were preschool aged children. Some of the screening was done in cooperation with other agencies (especially Day Care and Head Start). Some of the round-ups were held in conjunction with kindergarten registration.

ESD #121 Child Find Activities during 1979-80.

Since most severely handicapped children of all ages have already been identified, frequent and ongoing district contact with physicians, clinics and private agencies will generally be sufficient to obtain this type of referrals.

It is the less obviously handicapped preschool population, however, that districts need to identify. The most effective method for finding these children has been through developmental screening clinics which have been conducted in school districts throughout ESD #121.

Task Force

Most districts developed a Child Find Task Force made up of district personnel (Child Find Coordinator, CDS, OT/PT, kindergarten teacher, psychologist) and community representatives (private day care, public health nurse, DD program coordinator, Head Start representative, parents). This approach has several advantages. First, the child find Coordinator can rely on a cadre of interested and committed people to share the responsibility for planning and implementing activities. Second, community involvement will bring valuable community resources to the child find effort. Third, each person who serves on the task force represents a constituancy that will be directly affected by the child find effort; representation on the committee assures that their veiws will be heard and their expertise tapped. Fourth, the cooperation of people representing community agencies is more likely if they have participated in the planning efforts.

The initial task force meeting provides members with an overview of child find legal requirements and a review of the district's past activities. A program plan for the year is then developed, with ad hoc committees carrying out activities defined by the task force.

Screening

Once a decision is made to sponsor a developmental screening clinic, the next step is to decide whether to restrict screening to a particular age group, geographical area or population, children with suspected problems, etc. These decisions will affect the content and extent of publicity, screening locations(s) and instrument selection. Generally, the more restrictive the criteria, the fewer children screened, although those screened will result in a high percentage of children eligible for service. The one major disadvantage in restricting the population is that many children with problems or potential problems may remain unidentified. Parents or referring agencies such as Head Start may not be knowledgeable about behavioral or developmental indicators of problems; agencies may hesitate to refer for fear of labeling or singling out a few children for screening. If developmental screening is open to every preschool child in the community, the community is much more likely to actively respond. Parents who may suspect there is a problem or who have questions about their child's development are much more likely to bring their child in for screening if that concern does not have to be verbalized or otherwise identified prior to the screening itself. A less restrictive developmental screening also tends to result in more community awareness, newspaper articles, flyers going home with school age children, brochures sent to boxholders, posters displayed in grocery stores and laundromats and direct contact with health practitioners and other service providers have been typical

methods for providing community awareness. Some districts have opted to screen selected populations; the content and distribution of publicity is then designed to reflect these district priorities.

Another method of involving the community in child find is to use volunteers as screeners. Many districts have trained PTSA members and spouses of school board members to administer screening instruments; district staff conduct the initial entry and exit interviews and assist at various screening stations as needed.

Developmental screening, as one component of a district's child find activities, can be provided at minimal cost. Screening instruments can be borrowed from the ESD or from other districts. Volunteers from the community can provide some of the needed staff; the local high school can print the awareness materials or printers may donate their labor and materials as a community service. The more the community becomes involved, the more likely it is that child find will become a community effort, not just a district responsibility.

During this past year, 18 districts in ESD #121 conducted developmental screening clinics. At least two districts (Tacoma and Franklin Pierce) offer this service to their communities on a monthly basis. Approximately 2,300 preschool children were screened this past year; 140 or 6% were made a focus of concern. Most of the assessments have been completed and, with very few exceptions, these children are eligible to receive special education. As important, districts identified children with chronic ear infections and other medical problems that could be corrected. Parents were referred to local clinics and nurses provided follow-up to assure services were provided. Children experiencing minor developmental delays were either rescreened or referred to preschool co-ops, Head Start, nursery schools or other appropriate community programs. Parental concerns and questions were answered.

Benefits

Without exception, all districts reported that the effort was worthwhile; children eligible for special services were identified, agencies serving preschool children began communicating common interests and concerns, cooperative interaction between agencies assured a continuing dialogue, the general community became more aware of both normal development and potential developmental problems and parents experienced positive caring concern from local district personnel.

Finally, developmental screening clinics appear to be the most cost effective and efficient method for early identification of young handicapped children.

Summary Recommendations

I Analyze your district

a) Fill in demographic chart in order to determine who you are currently serving.
b) Review population trends in your district.
c) Stop, use some logic, and ask yourself "Where do we seem to be falling short in serving handicapped children?"

II Refine in School Referral Procedures

a) Do regular educators know how to make referrals?
b) Is this system efficient? Are there referrals? Can a teacher make a referral without undue hassle, without embarassment?
c) Is there a quick turn around on referrals?
d) Do you have building meetings or other formal times when referrals can be made on a frequent basis?
e) Are retentions reviewed on a regular basis?
f) Think about your secondary programs and the percentages of children being served. Are you satisfied that all secondary age children with handicaps are being served?
g) Are you screening for school age communication disordered children?

III Preschool Procedures

a) For the 1% severe the most efficient manner of locating these children in through formal agency contact. Get to know the staff at DD centers, public health agencies, diagnostic centers, as well as private primary care physicians. Most of these children ARE already identified by an agency. Remember - frequent contact is necessary.
b) For mildly involved children the most efficient procedure is formal screening. Contact Marsha Shearer (ESD #121) for guidelines. Also, formal contact with Head Start and Title XX Day Care programs is useful.
c) Awareness campaigns - posters in local business establishments using a wide range of descriptions for handicapped (in need of special services, learning problems, etc.) Be sure there is a contact number on the poster.
d) Use logic to try to determine where, given your population unidentified handicapped children might be located.

Chart 1

Total pop. in Dist.	2% Beh. Dis.	3.5% Comm. Dis.	.5% Orth. Handi	.5% Health Imp.	3% L.D.	1.8% Mild Ret.	.4% Mod. Ret.	.1% Sev/Pro Ret.	Mult. Handi	Neuro. Imp.	.575% Hearing Imp.	.1% Partially Sighted	.1% Blind
____ 3 y.o.													
____ 4 y.o.													
____ 5 y.o.													
____ 6 y.o.													
____ 7 y.o.													
____ 8 y.o.													
____ 9 y.o.													
____ 10 y.o.													
____ 11 y.o.													
____ 12 y.o.													
____ 13 y.o.													
____ 14 y.o.													
____ 15 y.o.													
____ 16 y.o.													
____ 17 y.o.													
____ 18 y.o.													
____ 19 y.o.													
____ 20 y.o.													
____ 21 y.o.													